THE AMERICAN JOURNAL of PSYCHIATRY

VOLUME 109
NUMBER 5
NOV. 1952

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Published by

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AMERICAN JOURNAL OF PSYCHIATRY
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Office of Publication, 1601 Edison Highway, Baltimore 13, Md.

Editorial communications, books for review and exchanges should be addressed to the Editor, Dr. Clarence B. Farrar, 113 St. Clair Avenue West, Toronto 5, Ontario, Canada.

Business communications, remittances and subscriptions should be addressed to The American Psychiatric Association, 1601 Edison Highway, Baltimore 13, Md., or to 1270 Avenue of the Americas, New York 20, N. Y.

Entered as second class matter July 31, 1911, at the postoffice at Baltimore, Maryland, under the Act of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized on July 3, 1918.

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CONTENTS

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Therapy for Vascular Headache to Reverse the Physiologic Disturbance

Headache, a problem encountered in all kinds of medical practice, may occur in association with any of a variety of disorders, some organic, others purely functional.

In headaches of organic etiology, e. g sinusitis, febrile disease, brain abscess — the primary objective is to eliminate the basic disease. Head pain can be relieved temporarily with analgesics, pending diagnosis and definitive treatment.

Functional types of headache present a greater problem, because of the obscure nature of their etiology and their recurrent nature. Among these are:

Migraine (both classical and variant forms)
Tension headache
Psychogenic headache
Histaminic cephalgia

Wolff and his co-workers established that the pain of these headaches is due to disturbance of the tonus of cranial blood vessels — hence the term *vascular headaches.*

The craniovascular changes associated with the several phases of the typical migraine attack are:

Vasoconstriction (Drawing I) — to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)

Vasodilatation (Drawing II) — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema (Drawing III) — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

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I

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VASOCONSTRICTION

II

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VASODILATATION

III

EDEMA

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1. **Take 2 tablets at first sign of attack.**
2. **If the attack continues take one additional tablet every half-hour until attack is terminated.**
3. **Do not take more than 6 tablets for any single attack or more than 10 tablets in any one week.**
4. **If attack develops more rapidly or is more severe than usual, take 3 or 4 tablets as early as possible.**
5. **If you notice any change in your symptoms, report to your physician immediately.**

.....M.D.

Do not take tablets between attacks.

2. Reduce the frequency of attacks — psychotherapy and regulation of living habits to avoid fatigue and nervous tension are most effective.

Supplies of Instruction Sheets as shown in facsimile above will gladly be sent on request; reprints of recent reports on Vascular headaches are also available.

GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull. 54: 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Shofstall, C. and Shofstall, W.: J. Kansas M. Soc. 52: 366, 1951. Wolff, H.: Headache and Other Head Pain, New York, Oxford University Press, 1948.

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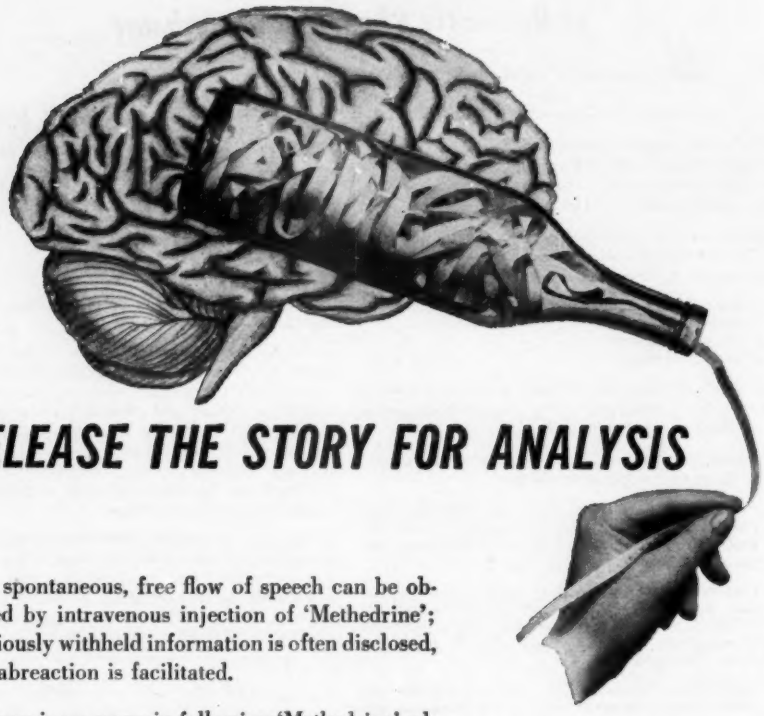

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Simon, J. L. and Taube, H.: J. Nerv. and Ment. Dis., 104:593, 1946.

Levine, J., Rinkel, M. and Greenblatt, M.: Am. J. Psychiat., 105:429, 1948.

Shorvon, H. J., Rook, A. J. and Wilkinson, D. S.: Brit. M. J., 1300, Dec. 1950.

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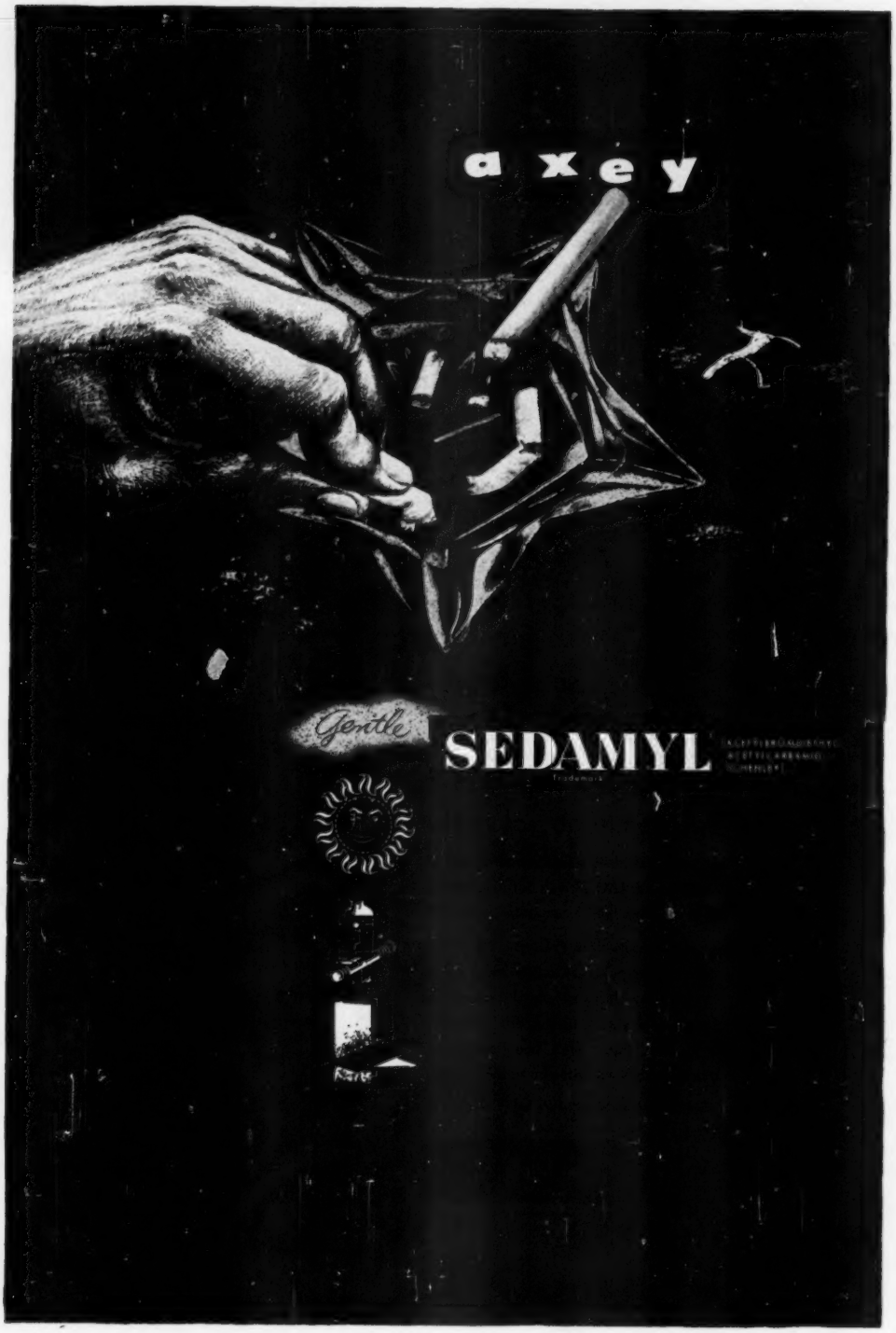
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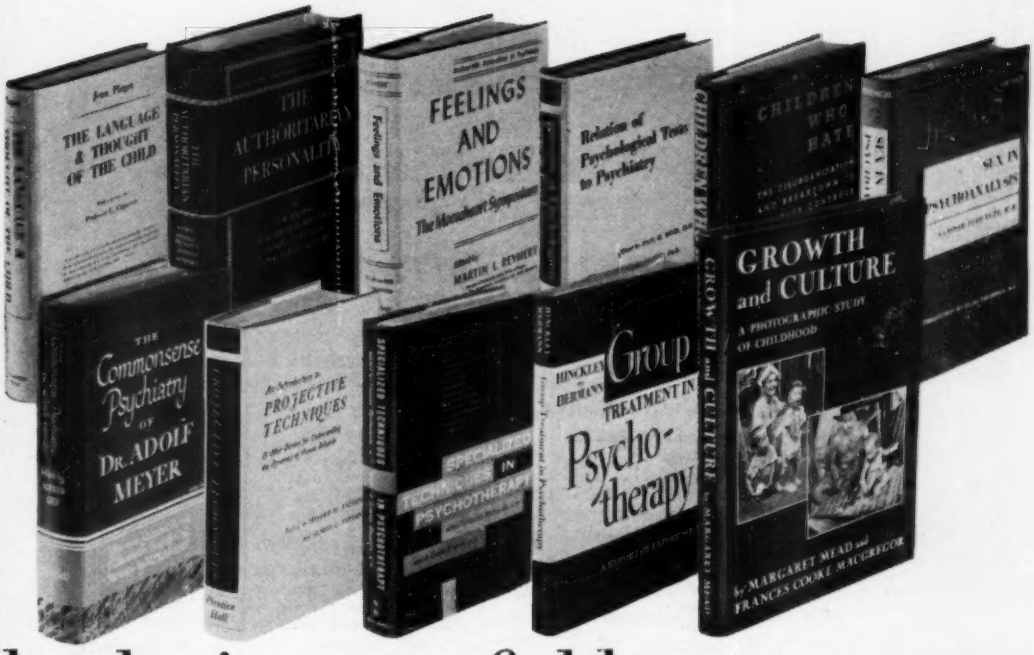

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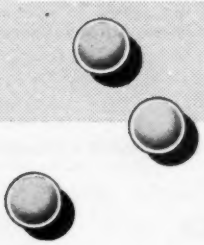

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JAPANESE PSYCHIATRY AND PSYCHOTHERAPY[1]

AVROHM JACOBSON, CAPTAIN, M. C., U. S. A. R.,[2]
AND
ALBERT N. BERENBERG, 1st LT., M. S. C., U. S. A. R.[3]

While on duty with the 141st General Hospital in Southern Japan during the Korean conflict, the authors participated in joint psychiatric clinics and seminars with the neuropsychiatric faculty of the Kyushu University Medical School in Fukuoka. Access was also gained to the several indigenous mental health facilities, clinics, hospitals, and correctional institutions. The classification and treatment of mental illness in Japan as well as the Japanese version of etiology were explained to us. Records and statistics were made available. In what follows we have attempted to describe some of the concepts of certain of the neuroses as well as the therapeutic procedures used.

First, however, a word about the scope of this paper. Though the major psychoses (their classification, the concepts concerning their etiology, and the therapies currently popular) are certainly deserving of detailed attention, because of the more fascinating and somewhat alien manner of treating the nonpsychotic mental disorders we shall devote the major portion of this report to the latter.

Generally speaking, the nomenclature and classification of psychiatric conditions is not uniform throughout Japan. There is an attempt to follow the classification of Kraepelin, but at best it is an approximation. Such diagnoses as "Commotion Psychosis, Reactive Insanity, Invocation Psychosis, Nervous Paresis, and Short Stature" are found in the "Statistics of Patients, Report for the Year 1949 of the University Neuropsychiatric Outpatient Clinic." "Paraphrenia" still enjoys general usage.

Making rounds through a closed ward pavilion one is impressed, indeed overwhelmed, by the assortment of descriptive diagnostic labels in the clinical records that are accepted as diagnoses. These records are kept in both Japanese and German. The "invocation psychosis" is in fact a paranoid schizophrenic reaction with religiosity dominating the clinical picture. "Psychogenic psychosis" is usually a schizophrenic reaction wherein there is no evidence of intellectual or emotional deterioration, and which is believed therefore to be nonorganic and more favorable in outcome than schizophrenia. The latter is considered organically based and essentially deteriorative.

The Japanese utilize many techniques in therapy that are common in America today, such as electroshock, continuous sleep, psychosurgery, etc. One cannot help being impressed by the docility of the average Japanese psychotic. However, seclusion rooms and physical restraints are used for the more acutely disturbed.

The psychiatric staff members of the Kyushu University Medical School are quite firm in their "non-Freudian" approach to mental disease. They explain their position by saying that Japanese psychiatry like Japanese medicine has developed under the strong influence of the Germans who have not, in their opinion, given support to Freudian theory. More basic than that, they claim, is their feeling that Freudian psychology is vague, presumptuous, and unscientific.

Of great interest to us were the unique concepts held concerning certain of the neuroses and the methods for their treatment. The most widely used system of psychotherapy in Japan today was developed about 30 years ago by Doctor Morita, professor of clinical psychiatry at Zikei University in Tokyo. He developed his method specifically to treat a group of neuroses that he called "shinkeishitsu." Literally translated, "shinkeishitsu" means nervousness. However, since this meaning is only approximate and misleading as well, the original Japanese term will be used in this paper.

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

[2] Chief, Neuropsychiatric Service, 141st General Hospital, Japan.

[3] Chief, Clinical Psychologist, 141st General Hospital, Japan.

Varieties of "Shinkeishitsu"

"Shinkeishitsu" is described under 3 subgroups: neurasthenic states, obsessive-phobic states, and paroxysmal neurosis.

a. *Neurasthenic States.*—The symptomatology of this subgroup corresponds roughly to that of neurasthenia. However, Morita could not accept the explanation prevalent at the time that the irritability and weakness observed in his patients were caused by an exhausted nervous system. He believed that, if nervous exhaustion were causal in neurasthenia, it should be cured by rest alone. But, since such therapy was ineffectual in almost all cases, he felt that other mechanisms were at work. He contended that, if it were simply a matter of nervous exhaustion, the patient would seek rest quite naturally and recover without ever having seen a doctor.

b. *Obsessive-Phobic States.*—This subgroup includes those patients who are characterized by recurrent and intense fear associated with an idea, object, or situation, as well as the persistent recurrence of unwelcome and distressing thoughts. Although the patient consciously recognizes that no danger exists and that there is no rational basis for his fear, he cannot help being fearful.

c. *Paroxysmal Neurosis.*—This subgroup is characterized by acute anxiety on a hypochondriacal basis. It is more or less equivalent to an anxiety attack with tachycardia, dyspnea, vertigo, and vomiting as the outstanding symptoms. These symptoms occur in paroxysms. Sometimes this is referred to as the "cardiac neurosis" because of the lay association of the symptoms with cardiac illness.

In summary, "Shinkeishitsu," as a group of related diseases, is characterized by compulsive acts, obsessive thinking, hypochondriasis, and chronic neurasthenia. In the first half of 1941 the Kyushu Medical School's neuropsychiatric service diagnosed 227 outpatients (8.7% of all NP outpatients) and 15 inpatients (3.1% of all NP inpatients) as suffering from this disease.

In their premorbid states, these patients are said to be extremely punctilious, rigid, fastidious, formal, meticulous and suffer from obsessive doubting. They are so perfectionistic that nothing they do satisfies them as a job well done. With their exaggerated sense of duty and their inability to make decisions they often become quiet, seclusive, and overinvolved with "self."

The first step in the transition from the premorbid character to the pattern of "shinkeishitsu" occurs when the patient becomes engrossed in hypochondriacal anxiety. Following that, contends Morita, there develops a "psychic mutual action." This is the mutual action between the patient's attention to the condition of his body or mind on the one hand and his sensations on the other. Attention and sensation are constantly interacting in such a way as to make the other progressively more sensitive and sharpened. This is a circular process in which, for example, a psychosomatic illness increases the anxiety of the patient, which in turn aggravates his illness.

Morita states that all 3 subgroups of "shinkeishitsu" can be understood on the basis of "hypochondriasis" and "psychic mutual action." In considering the life histories of these patients, he found that many of them were brought up in homes that were "too rigid or too permissive."

Morita's Therapy

Morita formulated a course of therapy that has been widely used in psychiatric clinics throughout Japan. The course of therapy consists of four definite phases: Phase I, "Absolute rest"; Phase II, "Light physical activity"; Phase III, "Moderate physical activity"; Phase IV, "Discipline by coping with the complex unpredictable problems of life."

During the first 3 phases of treatment, the patient is able to see and speak with only the doctor and nurses attending him. He may not speak with his family, friends, or with other patients or even staff members not directly concerned with him. The purpose of this isolation is to encourage introspection and "soul-searching," to promote a greater consciousness of self.

The *first phase* of treatment, which consists of absolute rest, continues from several days to a week. During this period the patient is observed for diagnostic purposes while he is able to recover from any physical or emotional exhaustion he may have. Morita believed that the patient suffering from "shinkeishitsu" is able to follow the doctor's

prescription of absolute rest, albeit with some anxiety. On the other hand, the hysteric and the early schizophrenic are unable to do so without considerable feelings of ennui.

In this phase of treatment, the patient is allowed to do nothing to help pass away the time. He is prohibited from speaking, writing, making his toilet, or performing any kind of handiwork. Even when the patient experiences strong anxiety he must continue to do nothing. In addition, he is kept completely unaware of the nature of his treatment. In no way is he given to understand that he will recover or how recovery will be effected since the feeling of expectation might disturb the "natural process of recovery."

A strong feeling of tedium is usually induced in the patient between the fourth and seventh days. During this time the doctor observes him in order to decide when sufficient tedium has been produced. At that time the patient is started on Phase II of his therapy.

In the *second phase,* the patient is still isolated from social intercourse, from speaking and from reading. However, he now begins to write in his diary every evening and must continue to do so until the end of his treatment. The diary is said to be a valuable aid to the psychiatrist in diagnosis and therapy. The regime remains rigid. The patient must get up and go to bed according to a strict schedule. He is not permitted to lie down on his bed during the day no matter how fatigued he may feel. He must go out for walks at specified hours.

The goal of this period, which lasts from 7 to 14 days, is to promote spontaneity of thought in the patient by forcibly restricting his physical activity. It is during this period that the patient will spontaneously demand to be allowed to perform certain tasks without any prompting at all from the doctor or staff.

In the *third phase* of treatment, which lasts from 7 to 14 days, the patient is at long last allowed to perform some moderately heavy work. Often, the old obsessive feeling that his work is inadequate shows up immediately. However, the doctor is now in a better position to show the patient how he is actually getting substantial gratification from the performance of his work. It is during this time that the patient, with the support of the doctor, is said to gain confidence in his skills and abilities.

The *final* and most difficult *phase* of therapy is to prepare the patient for a return to a complex social life. Under the supervision of his doctor he is encouraged to react less rigidly in meeting his everyday problems. He is trained to adapt himself to the changing stresses of his environment. The length of this phase of treatment varies.

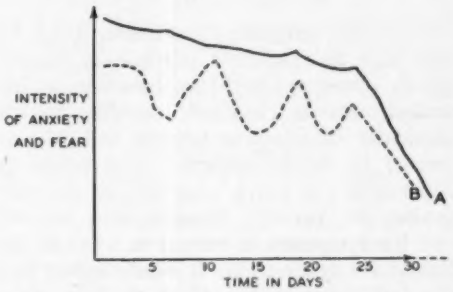

FIG. 1.—Results of therapy. This graph was shown to us by Kyushu University Faculty. It is a mixture of the qualitative and quantitative as shown by the nature of ordinate and abscissa. See Table 2 for the results of this psychotherapy for each subgroup. The best results were obtained in treating the paroxysmal neurosis. Average for total: 76.2% cured, 7.6% improved. Average time for treatment: 73.2 days.

The therapists who use Morita's method find their patients are usually quite skeptical as to the efficacy of this treatment. However, it does not seem to matter too much that the patient feels this way. According to Morita, the doctor need not at any time suggest to the patient that he is getting well. It is enough that the patient carries out the doctor's orders.

The process of recovery varies from patient to patient. It appears, however, that there are two essential courses of recovery. In one type (Fig. 1, Curve A) the patient feels little or no improvement during the first and perhaps the second phases of therapy. Then suddenly he may achieve insight into the "unrealistic and unhealthy patterns" that brought him to treatment. From that point on recovery is rapid and symptoms diminish appreciably.

In the other type of recovery (Figure 1, Curve B), improvement begins almost immediately, only to be followed by a relapse

accompanied by anxiety. This, in turn is followed by more improvement and so on. Some recovery is followed by some anxiety, the recovery being progressive until finally the patient is ostensibly free from his disease. Unfortunately there are no attempts at follow-up studies, and the reliability of the statistics given concerning cures is questionable to say the least.

Cultural Factors

From the foregoing description, it can be seen that the Japanese psychiatrist is primarily concerned with the behavior of his patient, who is classified according to his particular maladaptive pattern and who is treated by being subjected to a series of supervised corrective experiences. In particular, the patient's concern with himself and his symptoms is viewed as basic to his behavioral dysfunction. It would appear that the Japanese view the whole thing as character neurosis. One of the basic conditions for recovery is the development of what is generally called "a calm and well regulated mind." This, it appears, is not only the goal of modern psychiatry but has been the goal of Zen Buddhism for the past 800 years.

Not only the goal, but also the manner of achieving this goal is outlined in the 8 steps formulated by the first Buddha (Gautama Buddha). In order to achieve enlightenment or a serene and orderly mind, it was said by the Buddha, one should sit long and quietly, withdrawn from external objects and direct all thoughts inward. This bears more than a superficial resemblance to Phases I and II of Morita's psychotherapy as described above. Indeed, Morita himself states that his treatment of "shinkeishitsu" is essentially an extension of Zen Buddhism. This self-discipline is more than a matter of religion or philosophy. It permeates the life of the nation. From earliest infancy the Japanese is taught that the "will" should be supreme over an obedient body. Part of Morita's therapy is to master a recalcitrant and anxiously somatizing body through the power of the "will."

Another principle that is common to both Zen Buddhism and Morita's therapy is that of performing one's tasks and duties with such absorption that one is hardly aware of one's self. Often when an adolescent boy is overconcerned about the highly important middle school examinations that he must take, he is advised to "take it as one already dead" and pass the examination without any trouble. "To live as one already dead" is an important concept in Japanese philosophy. The Zen Buddhist calls this highly desirable state, "muga." It is a kind of ecstatic performance with no sense of "I am doing it." Filled with the ecstasy of "muga" the Japanese officer leads his men in a suicidal "banzai attack" with little or no conscious thought of the great peril to which he is exposing himself. If he performs "as one already dead," he achieves maximal efficiency in accomplishing his mission. Similarly on a smaller scale in sports and in the theater one becomes so absorbed in what one is doing or witnessing that the palms of one's hands may become wet with the "sweat of muga." This state differs from the Indian concept of Nirvana in that the Japanese seek their Nirvana here and now without any flight from the realities and pleasures of this world. In brief, "muga" is allegedly a release from internal tension and conflict and is therefore conducive to expertness in performance.

Another factor in the basic design of Morita's therapy is the rigidity of his system. The psychiatrist knows that the first phase of therapy lasts 4 to 7 days. He knows that the third phase lasts 7 to 14 days. In addition, during each phase of therapy, every activity of the patient is clearly prescribed. He may not speak to anyone but his doctor, etc. There are also rules set down to govern the conduct of the psychiatrist in relation to his patient. There are certain things that he must say and do and others that he may not. Everything is set down in black and white. This rigidity and planfulness is again a reflection of a much older Japanese cultural pattern. It is reminiscent of the elaborate codes that govern the behavior of the Japanese in almost every conceivable situation. From earliest childhood, the Japanese learns how to sit properly, what kind of bow he must give to people of different social standing, what manner of address is to be used in each situation and with each person, etc. In addition, he must learn his "on," his "giri," and his "gimu." [4]

[4] Duty to repay one's moral debts to the Emperor, the nation, one's parents, relatives, friends, business associates, profession, one's name, etc. Not even one

He soon takes his station in this rigid society wherein each person has his proper place in relation to every other. There is neither freedom nor disorder. One is respected for his ability to follow the various obligations incident to his loyalties as perfectly as possible. Outside intrusions and demands upon one's attention to his obligations are seen as pollutions despite their seeming desirability. Indeed does the young Japanese inherit the debts of the past!

In theory and seeming essence he has the map and the plan of security. As long as he lives according to the plan, he can predict with a fair degree of accuracy what is probably going to happen to him. Even those who cannot accept their roles without reservation must express their hostility only with blandness, humility, and the omnipresent smile. The Japanese knows that any deviation from the code is likely to be painful. Often it becomes necessary for him to become preoccupied with minutiae in order to escape from an awareness of his true feelings. The real threat comes from the unforeseen situation that cannot be handled by rote. Such a situation is often frightening and may even lead him to react in an irrational manner.

In the light of these and other cultural factors let us again consider the subgroups of "shinkeishitsu."

Neurasthenic Symptoms.—It is surprising to find such low incidence of sexual dysfunction contrary to the findings so frequently discussed in western textbooks under the heading of neurasthenia (see Table 1). It is possible, of course that the figures reflect a reluctance on the part of the patient and/or the psychiatrist to discuss such matters, but it hardly seems probable when it is considered that sexuality is not nearly as taboo a subject as it is in western countries.

It is a matter of tradition that the Japanese consider neither sex nor any other human feeling to be evil. On the contrary, the feelings are thoroughly good, provided they remain completely within the control of the individual. The authors were surprised to learn how permissive was the Japanese parent's attitude toward infantile and juvenile masturbation. The Japanese child is not told that God will punish him for such transgressions or that he will lose his mind or that it is dirty or that he will become a physical weakling. He is neither threatened nor ca-

TABLE 1

SYMPTOMS CHARACTERISTIC OF "SHINKEISHITSU"

Symptoms	No.	%
A. *Neurasthenic states* (*simple hypochondriasis*) (519 cases)		
Feeling of pressure on head	217	41.8
Poor memory	186	35.8
Disorder of sleeping	159	30.6
Headache	99	19.1
Physical and mental fatiguability	45	8.7
Lack of concentration	45	8.7
Feeling of dizziness	44	8.5
Difficulty of thinking, deciding, understanding	37	6.6
Sexual impotence	34	6.5
Feeling of langour	30	5.8
Feeling of clouded consciousness	27	5.2
Irritability	27	5.2
Tinnitus	25	4.8
Nocturnal emission	25	4.8
Tense feeling in neck and shoulder	24	4.6
Ejaculatio praecox	18	3.5
Paraesthesias	15	2.9
Gastrointestinal complaints	15	2.9
B. *Obsessive-phobic states* (262 cases)		
Fear of disease	85	32.4
Fear of people	43	16.4
Fear of blushing	33	12.6
Fear of dirt	26	9.9
Persistent doubting	26	9.9
Fear of ugliness	15	5.7
Persistent recurrence of unwelcome thoughts	14	5.3
Fear of committing a crime	11	4.2
Fear of being watched closely	8	3.1
Fear of activity	7	2.7
Fear of bacteria	6	2.3
Fear of pointed objects	5	1.9
Fear of space	5	1.5
Fear of high places	3	1.1
C. *Paroxysmal neuroses* (40 cases)		
Fit of palpitation	23	57.5
Fit of difficult breathing—dyspnea	8	20.0
Fit of dizziness	6	15.0
Fit of vomiting	4	10.0

joled. It is not considered sufficiently important. Autoeroticism is considered to be a pleasure about which there is no reason to feel guilt as long as control over it is not lost.

Even the adult is relatively free from guilt over any autoerotic practices in which he might engage. It is true that the constant

ten-thousandth of each debt is considered repayable, such is its magnitude.

influx of western ideas of morality is changing this pattern but still Japan remains unique even in this, her transition phase. One may still obtain highly ingenious autoerotic devices such as the "remotoma" [5] in this country. If they are not as available and as well advertised as they were before the war, it is perhaps because the Japanese appear to have become increasingly sensitive to any hint of ridicule from the western nations.

Their attitude toward homosexuality is a case in point. In old Japan, it was quite proper for a priest, samurai, or other high ranking person to keep a young boy as he would a mistress. It was a privilege of status.

During the Meiji reform when Japan was westernizing at an unprecedented rate, homosexuality was declared to be illegal and punishable by law. It was not a question of moral judgement but rather a legal import from the west that seemed to go along with the steam engine and mass production. Today, homosexuality is still treated as a legal rather than moral or even psychiatric problem. Even so, it has been of comparatively minor importance until now. At present, Japanese psychiatrists have noted an increase in the incidence of homosexuality in large cities such as Tokyo and Osaka. These cities are among the most westernized in Japan and are becoming even more so as a result of the Allied occupation.

As for the impact of the Allied occupation on Japanese morality, it is at least considerable. It will be difficult to appreciate the full significance of the changes that have taken place in the Japanese way of looking at things for some time to come. An interesting and comparatively recent innovation is the increased overt sexualization of the female breast. Before the advent of the Army of Occupation, the American movie, and the adoption of American styles of dress, the breast was considered to be primarily an organ of lactation. When not in use it was apparently nonexistent under layers of clothing and a tightly wound girdle. Today, much of that is changed. In almost all the large cities, western dress has supplanted the traditional Japanese kimona. Breasts are supported and emphasized by foundation garments that are now receiving unprecedented popularity. Those women who are more modestly endowed are now purchasing "chichi kata" or breast pads, the sale of which is said to be very great. Sweaters and provocative necklines are to be seen everywhere.

Along with this, there is a greater tendency toward the western conception of modesty. Nonetheless it is difficult for a nation to change its ways in just a few years. It is true that there are separate entrances now for men and women in the public bath houses, but once they enter they disrobe completely and use the same bathing pools with complete equanimity. To a large extent, a separate toilet for each sex is a luxury reserved for foreigners. Even in modern Japanese theaters the water closet is shared simultaneously by both sexes without embarrassment. In fact it is a common sight even in the large cities to see a citizen complacently urinating in the street. No shame is observed, no notice given by passersby.

The Japanese seems to compartmentalize his sex life. Taking a bath in mixed company is one thing and is not to be confused with sex, *per se*. There are even compartments within the compartments. A man may be married and still openly seek erotic pleasures outside the limits of his nuptial mat without incurring either guilt feelings or social disapproval. His wife may not be overjoyed at such a prospect but she will often lay out his clothing and help him dress for an evening of relaxation at a geisha house or perhaps the more modestly priced house of prostitution. Nonmarital sexuality provides erotic pleasures that are apparently not available in husband-wife relationship and vice versa.

Although the foregoing has in no way approached an outline of Japanese sexuality, it is believed that enough has been said to indicate that the Japanese pattern and approach to sexuality are different from ours. The low incidence of sexual dysfunction in the Japanese male as reported by Kyushu Medical School may then perhaps be regarded as a function of the cultural traditions of this country. Unfortunately, the authors were unable to find anything resembling the exhaustive surveys on sexual habits that have

[5] A female masturbatory device consisting of a solid metal ball within a larger hollow ball, which is inserted into the vagina and held in place by a tampon. Thereafter with each movement the smaller ball rolling within the large provides constant erotic stimulation.

been made in America. Our inquiries met with vague replies and amused tolerance, but recorded figures were lacking.

Obsessive-Phobic Symptoms.—In considering the obsessive-phobic states (see Table 1), the high incidence of some symptoms undoubtedly reflects cultural patterns. Thus, the pathological fear of disease is to be expected in a country where even the normal individual is obliged to exercise vigilance in order to maintain his health. Fear of dirt is not too far removed from fear of disease. The high percentage of obsessive-phobics who suffer from fear of blushing seems to reflect the Japanese feeling that loss of control over one's emotions is something highly undesirable. It is also interesting to note that fear of ugliness is a close runner-up to fear of dirt. These are related by more than their closely equivalent percentages in Table 1. Dirt and ugliness are homonymous in Japanese. When an object is referred to as "kitanai," it could be ugly, dirty, or both. The listener need not always decide which characteristic applies since there is a gradual blending of meaning from one to the other. Conversely, the opposite of "kitamai" is "kirei," which means clean and/or pretty.

Paroxysmal Symptoms.—The influence of the language of the Japanese is no small factor in shaping their formulations on mental disease and its treatment. Thus, a whole subgroup of "shinkeishitsu" is referred to as a "paroxysmal neurosis," while each of its symptoms is given in terms of "fits." There is a fit of palpitation, a fit of dyspnea, etc. The whole thing sounds like an organic convulsive disorder. Indeed, the Japanese psychiatrist is very much attracted to the organic approach to his speciality. The research at the Kyushu Medical School department of neuropsychiatry seemed to be almost exclusively of the organic variety. It seems paradoxical that a nation whose cultural patterns are so imbued with myth and tradition should seek to disavow these in psychiatry. Its studies are concerned with measuring of details, the usefulness of which is questionable, while social factors are given but passing notice.

Morita's therapy is said to be most effective with the paroxysmal or cardiac neuroses. Unfortunately, the study available included only 7 cases in this category. One hundred percent of these cases were treated "successfully" as shown in Table 2. Even when the entire 105 unselected cases reviewed at Kyushu University are considered, we still have 76.2% "cures" and 7.6% "improved" or a total of 83.8% of all cases who responded favorably to this treatment.

In our opinion the validity of these statistics is questionable. The lack of follow-up studies to check their "cures" has been mentioned above. By the term "cure" the Japanese mean conforming behavior rather than the patient's own feeling of well-being and lack of conflict. The Japanese patterns of behavior are meticulously prescribed and one must conform. No reservations or substitutions allowed! Even their statistics conform. However, it is soon apparent that much is excluded in their studies. They do not appear to investigate the foundations and ori-

TABLE 2

RESULTS OF TREATMENT AT KYUSHU MEDICAL SCHOOL, 1950-1951

	Cured	Improved	Unchanged	Stopped treatment	Complicated other mental diseases	TOTAL
Neurasthenic states (simple hypochondriasis)	30 (78.9%)	2 (5.3%)	2 (5.3%)	3 (7.9%)	1 (2.6%)	38
Obsessive-phobic states	44 (73.3%)	5 (8.3%)	4 (6.7%)	5 (8.3%)	2 (3.3%)	60
Paroxysmal neurosis	6 (85.7%)	1 (14.3%)	0	0	0	7
TOTAL	80 (76.2%)	8 (7.6%)	6 (5.7%)	8 (7.6%)	3 (2.9%)	105

NOTE: Period of time used for this treatment:
Maximum: 180 days
Minimum: 13 days
Mean: 73.2 days

gins of neurotic behavior. They make little attempt to understand the ambivalent feelings of patients toward authority figures. Sociologic factors are barely considered. Obligation or "on," which has such a powerful influence on all phases of Japanese activity, is not mentioned in their reports. Techniques aimed at de-repression are looked upon as wasteful of time and antithetical to the goals they have set for themselves. They seem rather to approach the patient with a mold into which they force him. After a period of "setting" or "fixing" the mold is taken away and the patient steps out properly "cast" or back he goes for "re-casting." The neuroses are thought of in general as behavior disorders in our sense of the word. The stress factors acting upon the patient although recognized and often listed are rarely investigated as minutely as in western therapy. Sources of conflictual material are not sought after. Dreams are given but scant attention. Though occasionally one hears the use of the term unconscious, it is usually employed to denote sleep rather than a state of mental and emotional activity not readily apparent to the individual. Transference phenomena are not mentioned, and apparently very few Japanese psychiatrists bother investigating their own countertransferences. It is interesting to note that delusions are classified according to content. Thus there are "delusions of religion," "delusions of invention," "delusions of importance," etc. No attempt is made to uncover the reasons for the presence of delusion. Suppression is the dominant theme in therapy; conformity the goal! There are a few dynamically oriented psychiatrists but they are pitifully few and apparently of little influence in Japanese psychiatry. There are many areas in Japanese psychiatry deserving of certain investigation and interpretation in the light of cultural and language differences. Increased understanding of the Japanese is obviously a must in our future plans and policies. Psychiatrists and social anthropologists have before them a most fertile field of investigation, which is ripe for harvest.

Summary

An attempt is made to give some of the philosophy and methods that underlie present-day Japanese psychiatry. A brief discussion of psychosis is given. The classification of "shinkeishitsu" with its subgroupings of neurasthenic states, obsessive-phobic states, and paroxysmal neurosis is outlined and discussed. Morita's 4-phase therapy for treating "shinkeishitsu" is presented together with statistics compiled by the Kyushu University Medical School department of neuropsychiatry. Cultural factors such as Buddhistic influences, national traditions, and cultural patterns are elaborated where they relate to the classification and treatment of mental diseases in Japan. Symptoms characteristic of "shinkeishitsu" are listed with their frequency of occurrence as they were observed at the Kyushu Medical School Clinic. An attempt is made to explain these symptoms on the basis of cultural and historical factors. Some of the limitations of the Japanese approach to psychotherapy as exemplified by Morita's treatment of "shinkeishitsu" are discussed.

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DISCUSSION

YASUHIKO TAKETOMO, M. D. (Worcester, Mass.).—Two points were brought out in this paper that are misleading.

1. The activity described here pertains to only one of some 40 different medical centers in Japan, many of which have their own characteristic approach and viewpoint. Evaluations of psychopathology and treatment of American, English, French, German, Swiss schools, etc., are intensively under way at the different medical centers. Therefore, there is a serious danger of false generalization if this paper were regarded as a *survey* of "Japanese Psychiatry and Psychotherapy." The authors' review of Morita's method of psychotherapy is a contribution to mutual understanding of one of the varieties of psychotherapy as practiced in our 2 countries, but should certainly not be regarded as "characteristic." In addition to organic approaches, different aspects such as projects in clinical psychology or the development of mental hygiene activities should be pointed out.

2. The interpretation of Japanese culture as explaining the types and nature of neuroses in Japan seems premature and based on a rather fragmentary picture of Japanese life. The attempt is both interesting and important, but it should await fuller and more adequately controlled investigations before drawing conclusions.

AVROHM JACOBSON (CAPTAIN, M. C.).—In answer to the points raised by Dr. Taketomo we should like to point out that the introduction to this paper indicated quite explicitly the source of our information. Our statistics and personal observations were from the Kyushu University Medical School. However, the findings were discussed with members of medical faculties in other areas of Japan without adverse criticism being raised.

The projects in clinical psychology and those of mental hygiene activities are but in their infancy. We did not believe that the time limitations of this paper warranted discussion of those activities.

The second point of Dr. Taketomo's dealing with our "interpretation of Japanese culture as explaining the types and nature of neuroses in Japan," we believe, though perhaps "premature," is nonetheless called for by the demands of the time. To be sure, there is need for "fuller and more adequately controlled investigators," but there is also a need for a realistic facing of facts. We need to know more about Japanese culture and neuroses. World War II partly indicates the degree of our ignorance along those lines. The Japanese themselves have not heretofore presented us with the studies asked for by Dr. Taketomo. We do not feel that we can afford the luxury of a "complete and controlled study" as a first venture into the understanding of the Japanese in sickness and in health.

SOME CHARACTERISTICS OF THE PSYCHOPATHOLOGY OF SCHIZOPHRENIC BEHAVIOR IN BAHIAN SOCIETY[1]

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INTRODUCTION

Within the last 2 decades an increasing awareness of the significance of the cultural determination of human behavior has become manifest generally in the Sciences of Man. For psychiatry, particularly, the expanding interest in the holistic study of man has been unusually rewarding in terms of the enhanced status of psychiatric theory in the social sciences as well as in the added meaningfulness to psychiatry of cultural and social phenomena.

The success of psychodynamic hypotheses in the interpretation of behavior disorders and the extensive application of psychodynamic theory to general personality functioning and organization provide both the concepts and the investigative impetus to enliven the collaborative integration of the subject matter of the social sciences. As the reciprocal value, anthropology and sociology are giving psychodynamic theories a crucial testing in cross-cultural applications and in studies of comparative and demographic psychopathology.

Historically, the contemporary concern of psychiatry with the social and cultural matrix of human behavior represents a renascence of interest after an interval of the first 30 years of the current century, during which psychiatric attention, led by psychoanalysis, was progressively intraverted in psychologically productive and fertile study of the intrapsychic happenings of man.

In the last decades of the nineteenth century, psychiatry was also ready, then as now, to develop a social and cultural area of research, both for theoretical and practical purposes. Then, the nosologic and etiologic tasks of psychiatry seemed to be either solved or well on the way to solution, and psychiatrists sought to extend the limits of the behavioral horizon. After 1870 an increasing number of observations were made on the ecologic, sociologic, and cultural determinants of behavior disorders.

In those years, for example, it was possible to read in the psychiatric literature assertions that "lunacy" incidence, population density, and pauperism were positively correlated(2), that an "excessive proportion of melancholy" was admitted to the asylums of England and Wales following the economic depression of 1875(4), that insanity in Japan was more prevalent among the married than the unmarried(15), that melancholia and attempted suicide were far less common among the natives of British Guiana than in England (18), that in the asylums of Paris a British visitor could detect national character in the fact that "the children were much more talkative and demonstrative than English idiots usually are"(17), that in American asylums the patients were much noisier and more disorderly than in British psychiatric hospitals (14), that "no one of experience can escape the impression that the composition and behavior of asylum populations differ a good deal in different parts of Germany"(12), that, in the year 1889, Norway admitted 5% more melancholics than maniacs into its psychiatric hospitals, while in the same year England was diagnosing 24% more patients suffering from mania than were admitted with a diagnosis of melancholia(6), that the "delusions of the insane are merely the reflex or shadow of the prevailing beliefs of the age in which they live"(11), that "French hysteria doesn't exist in England"(5), that, contrarily, some hysterical patients at the Chicago County Hospital were like the hysterical women of France(7), that "in every

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

This study was financed by a grant from the Viking Fund and was facilitated by the cooperation of Professor Ralph Linton of the Department of Anthropology, Yale University, Professor Charles Wagley of the Department of Anthropology, Columbia University, Dr. Anisio Teixeira, Secretary of Education and Health, State of Bahia, Brazil, and by Dr. Oswaldo Camargo, Superintendent of the Juliano Moreira Hospital, Salvador, Bahia.

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country the proportion of suicides is one woman to three men"(1), that "we can point to the rarity of mental illness . . . . in uncivilized peoples; to the enormous increase in the number of insane persons requiring care in all civilized nations and to the increase of suicide . . . . in the great centers of civilized countries . . . ."(1), and, finally, that "the study of the individual as an element of social pathology will plainly be a long, laborious and difficult business of the future"(11).

Kraepelin, the great clinical psychiatrist of the closing nineteenth century, who personally exemplified the significant psychiatric trends of his times, became in his later years an anthropologically interested investigator. He had already spent 5 years in Estonia as professor of psychiatry in the University of Dorpat. About 15 years later he made a psychiatric tour of several different countries and concluded, in general, that the same clinical clusters of behavioral traits that formed his diagnostic classification could be found in all cultures(8).

However, significant frequency differences existed. Mania and melancholia, as an illustration, were described as of rare occurrence in Java, and a clinical difference in psychopathology was also indicated in that ideas of having sinned were never expressed as part of a depressive reaction. Kraepelin also saw no cases of alcoholic psychosis among the Javanese. Contrastingly, dementia præcox was a frequently occurring disorder and the presenting symptoms appeared to Kraepelin as the same psychopathology he had described in Europe. This latter conception of the cultural constancy of the psychopathological characteristics of schizophrenia so affirmatively described by Kraepelin was reiterated by Mayer-Gross in Bumbe's *Handbuch der Geisteskrankheiten* and more recently has been enunciated by Laubscher(10) in his studies on schizophrenic reactions in the Bantu.

A survey of the contemporary literature on culture and psychopathology demonstrates that the essential tasks both of delineating the prevalence and of describing the psychopathology and the psychodynamics of behavioral disease in various societies are in only the preliminary phases of scientific execution. Cross-cultural comparisons of the frequency of schizophrenic disorders, for example, can be accomplished only by painstaking community studies in which psychiatrists and cultural anthropologists work in long-term collaboration. We do not yet have the results of such community research even in our own society.

In the comparative cultural evaluation of the behavioral expression and meaning of schizophrenia, we are confronted also by problems of the methods of study. In preliterate societies, as an illustration, the desirability and, indeed, the necessity of studying the schizophrenic person through the interpersonal medium of intensive psychotherapy has been actualized by only a very few investigators, notably by Wulf Sachs and by Devereux. Many other methodological considerations in the general area of culture and personality research are, of course, relevant to the interdisciplinary study of culture and psychopathology.

An attempt to come to terms with the research needs of the psychiatrist and anthropologist as they cooperate in actual field work is now being written. The data of the present paper, however, represent a by-product of an experience in which a psychiatrist worked in the field in association with a team of anthropologists in an effort to understand the applied methods of anthropological research and to encounter at first hand the task of studying psychopathology in a society other than his own and with particular reference to a correlated anthropological description of the society and of its culture. The observations presented here are a preliminary report of part of this experience.

Methods

The State of Bahia, Brazil, in cooperation with the Department of Anthropology of Columbia University, has been engaged in extensive anthropological and sociological research as a prelude to the planning of educational and health programs for the rural areas of the state. Community studies with a common plan and orientation have been carried out in 3 different ecological zones of Bahia. There is thus now in existence considerable cultural information about representative communities in Bahia, which can be used for the consideration of possible cultural de-

terminants of the psychopathology of this area.

Since the time limits imposed on the psychiatrist in the exploratory study allowed only the most casual introduction to actual case-finding in the community itself, it was decided that the psychiatrist could get a superficial but comprehensive view of the schizophrenic reactions, particularly, by concentrating his study on the patients admitted to the state psychiatric hospital in the city of Salvador, the capital of Bahia. About 80% of the patients of the Juliano Moreira Hospital originated in the rural parts of the state and many of them were from the 3 ecologic areas studied by the anthropologists.

Approximtely 85% of the hospital patients were of the lower class and 15% were middle class. From the ethnic point of view, Bahians generally represent, as Pierson(13) observes, "a multiracial class society . . . . These classes are still largely identified with color, it is true, but they are classes nonetheless and not castes. The most characteristic tendency of the Bahian social order is the gradual but persistent reduction of all distinguishing racial and cultural marks and the fusing, biologically and culturally, of the African and the European into one race and one common culture." The hospital population was predominantly blacks and mixed-bloods, largely illiterate, and a majority exhibited behavior patterns, particularly in religion, demonstrating both African and Brazilian influences.

Two hundred of these patients with an already existing diagnosis of schizophrenia were studied by scrutiny of their hospital records, by single and occasionally serial interviews, by participant observation in the hospital life-space, and, selectively, by projective tests.

Observations

The social organization and interaction within the Juliano Moreira Hospital were conditioned by a number of factors. The waking activity of patients was centered in large outdoor areas adjacent to the buildings, which were used only for night shelter. The psychological distance between psychiatrist and patient, based largely on the social class and hospital role difference, was striking. After the acute admission phase of their illness, low-class patients, particularly, generally related to the physician by passive and submissive attitudes. The unhesitating obedience of many schizophrenic patients was noticeable. So, too, as in East Indian schizophrenic behavior, overt impulsive and aggressive activity on the part of patients toward any of the hospital personnel was very little in evidence. Such behavior may be due, however, to the characteristics of the hospital organization rather than to culturally determined differences of personality.

Women much more commonly verbalized their aggressive and other fantasies and feelings than did the men. On the other hand, even the most acutely disturbed women retained their early-learned habits of modestly arranging their dress between their legs when squatting in the habitual sitting position.

This more open expression of ideation and feeling by female psychiatric patients may probably be based on the child-rearing differences in the severity of discipline related to learning how to satisfy sexual and aggressive needs and on the cultural patterns of action for male and female behavior. Bahian psychiatry, nonetheless, is prone to place a diagnosis of manic-depressive psychosis, manic phase, on such behavior because of the "affective" characteristics. As a result, the male-female ratio in manic-depressive disorder is 1 to 4 in Bahian statistics. Since in the low-class patient depressive reactions are extraordinarily rare, these figures apply almost entirely to the diagnosis of manic excitement. A restudy of such patients by the author indicated that in his own clinic most of these reactions would be called schizophrenic.

With reference to depressive reactions, it is incidentally interesting to note that, among the low-class patients, no instance of suicide had occurred inside the hospital within the last 10 years.

The lack of any formal psychotherapeutic contact between psychiatrist and patient raises the basic question of the state of psychiatric science in this society, but it is also related to the problem of the patient's hospital and social role and status and, additionally, it is closely involved with the cultural behavior about privacy and intimacy. The conception of the privacy of a psychiatric

interview was not a part of the organizational behavior of the hospital.

If we turn our attention more specifically to the patients exhibiting schizophrenic behavior, one of the most interesting findings is that, in 106 of 200 randomly selected cases of schizophrenia in persons under 40 years of age, one or both parents were dead by the time the patient first entered the hospital, at an average age of 24 years. The high mortality of the general population must be considered but, even so, other determinants must also account for such a high proportion of parent-bereaved individuals in the hospital population. Again, it would appear that only community studies directed to case-finding in a specific region and an assessment of how the selectivity of the hospital operates could determine whether in this society there is a positive correlation between schizophrenic incidence and disrupted homes. Moreover, in Bahian family structure, with usually at least the mother's near kin residing in the same house or nearby, the possibilities of substitute mothering and of the presence of several parental figures change the meaning of parental loss from the experience in the relatively isolated conjugal American family.

From the hospital records of these patients there was also overwhelming evidence of lifelong difficulties in the maintenance of object-relationships and of the presence of early avoidance and withdrawal habits. One must be aware, however, that the hospital histories were records of a rather minimal communication between doctor and patient.

However, the avoidance-withdrawal behavior of the hospital patients was rarely so pronounced as to lead to stupor and, almost without exception, the schizophrenic patients entered readily into at least a momentarily responsive and meaningful relationship. The behavior of both the chronic and of the acute schizophrenic individuals seemed to be characterized by much less anxiety referable to other persons than in similar disorders in our own culture. This observation is admittedly difficult to document validly, but one acutely catatonic girl, for example, spoke to me in spite of the fact that she was retaining food in her mouth and had widely dilated "catatonic" pupils and other gross neurophysiological indices of extreme fear and of almost complete motor inhibition. She said that she believed in the spirits and that she was afraid of them but, she added, "I am not afraid of people because they are human beings."

In general it seemed to be true that for the low-class rural patient, especially, anxiety, fear, and the threat of retribution were interpreted as arising from the cultural deities, either predominantly African or Catholic. So, too, for most of the low-class men and for the majority of both lower and middle-class women, the delusional restitutional symptoms, either megalomanic or persecutory, were fantasied in terms of the cultural religious institutions. Middle-class men, however, much more frequently "secularized" their restitutive narcissistic and self-esteem delusions in terms of economic and class conceptions of power. Their paranoid ideas much more commonly involved the threat and persecution felt to arise from other men. Certainly some of this difference in psychopathology between lower and middle-class men may reside in the fact that in Bahia the middle classes identify with the upper and take on intense mobility needs. The lower class Bahian has no self-conscious class aspirations. Moreover, class mobility in Bahia is usually associated on the part of the male with a somewhat lessened involvement in religious behavior.

In a somewhat similar differentiation for which the class designation serves as a convenient index, paranoid ideas utilizing conceptions of impersonal causation, such as electricity, were found only in the relatively educated middle-class person. Such patients were found, for example, only in the Sanitoria de Bahia, a private psychiatric hospital.

Psychiatric anthropological research in Bahia derives a rich tradition from the early work of Nina Rodrigues and Artur Ramos directed to the study of the Afro-Brazilian Candomblé or possession ceremonies. The intimate connection between the culture-pattern behavior of the Candomblé and the individual psychopathology was obviously demonstrated in the schizophrenic and other hospital population. Ruth Landes(9) in her report on Bahia quotes a previous superintendent of the Juliano Moreira Hospital as saying that very few Candomblé women ever appeared in the psychiatric hospital. Certainly it is true that in absolute numbers only a small

proportion (approximately 3-5%) of the female psychiatric patients could be established as having been actual members of Candomblé cults. Unfortunately, there are no statistics on the proportion of Candomblé participants to the general female population.

Observations on the psychodynamics of Candomblé organization are being detailed elsewhere. Here, it may be profitable to think that the complex patterns of behavioral action institutionalized in the Candomblé may be used by different individuals in different ways for the recurring periodic gratification of several needs. Nevertheless, whatever needs, both conscious and unconscious, any one individual may be satisfying by means of Candomblé behavior, such an individual must be in sufficient control of autistic and regressive behavior and of reality-testing to be acceptable within the relatively rigid ritualistic group action. Hence, no frankly schizophrenic person would be able to pass the probationary scrutiny. Similarly, individuals who utilized hysterical dissociative behavior in an idiosyncratic way apart from the induced dissociative experience of the ceremonies were also excluded from the group. Successful initiation into the Candomblé groups was accompanied, therefore, by considerable psychopathologic screening.

One interesting correlative observation concerns the apparently low incidence of gross hysterical dissociative reactions among the low-class Negroes of Bahia. There were also some women who associated themselves with the Candomblé group but who could not experience the socially induced dissociative "possession." Interviews with these women usually demonstrated unusual anxiety or definite stubbornness and hostility.

The content of the Candomblé behavior, however, played a significant role in the thought and action of the female schizophrenic low-class patient. Some of the acute schizophrenic reactions, particularly, were characterized by the acting out of being possessed by an African god or goddess as in the Candomblé. The clinical picture was definitely schizophrenic and not simply hysterical and usually occurred as a reaction to a situationally acute stress or deprivation. The major psychological goal achieved in the psychotic resolution seemed to be an identification with the omnipotent deity similar to the brief and transitory introjection and identification achieved by Candomblé participants during the possession dances.

The Yoruban Candomblé groups, it seems certain, do not function in such a way as to allow for the institutionalization of psychotic behavior. The Caboclo and Macumba derivatives, however, seem to be composed of many more behaviorally deviant individuals and, indeed, as is evidenced elsewhere(16), may have a different psychodynamic organization.

Nevertheless, it is obvious that the people themselves do not make distinctions between acceptable and nonacceptable behavior by using definitions of psychopathology. As a matter of fact, a cross-cultural survey of the operational definition of behavior disorders is, in itself, a research problem in culture and personality study. Among the lower class Bahian, the presence of hallucinatory experience would be accepted as a normally conceivable but not necessarily commonly experienced happening. So, too, delusional speech, particularly of a religious nature, would not lead to a community definition of disordered behavior. On the other hand, uncontrolled aggressive behavior would easily evoke the designation "malucco" and lead to commitment.

The other side of the problem of the definition of psychopathology in relation to its cultural setting concerns the anthropologist and psychiatrist who seek to study the behavior disorders of other societies. One conviction of the present investigator arising from a serious attempt at anthropological field work is that statements like "this society has practically no psychosis" are meaningless. Indeed, my own experience, though limited, has been that the assessment of the incidence of behavior disorder is a function of one's case-finding techniques. These, in turn, depend upon the relatively long-term application of anthropological skills in knowing and describing the community. Moreover, only an experienced psychopathologist can hope to do an adequate assessment of the psychopathology of a community. Therefore, the psychiatrist must join the anthropologist in the field and develop the appropriate methods of study.

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UTAH'S EXPERIENCE WITH THE NATIONAL DRAFT ACT FOR HOSPITALIZATION OF THE MENTALLY ILL[1]

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Three years ago, a group of Utah citizens began a study of their state laws relating to the care and hospitalization of the mentally ill. This interest was, of course, in line with and stimulated by similar activities throughout the country. The Governors' Conference in June, 1949, directed the Council of State Governments to study and report on the nationwide activities in that field, and other organizations throughout the country were making similar surveys. In Utah the Women's Legislative Council assumed the major share of the responsibility for the study; and, largely as a result of their energetic and determined approach, the state laws dealing with the problems of the mentally ill were completely revised. The proposed revision was approved by the State Legislature in May, 1951.

During this period the personnel in the department of psychiatry, College of Medicine, University of Utah, were in a very favorable position to participate in the study of the older law, the revision of that law, and the community education program that led to its acceptance by the Legislature. In the area of community education alone, members of the department of psychiatry averaged, for 18 months, more than 3 addresses per week to lay and professional groups. Further, since the teaching hospital of the College of Medicine was developing an active psychiatry service that maintained close liaison with the Utah State Hospital, members of the department had ample opportunity to observe the actual handling of mentally ill patients under the old and the new laws.

Study of the previous law revealed that the deficiencies were so far-reaching that wholesale revision was indicated. Since the National Institute of Mental Health, the Public Health Service, and the Office of the General Council in the Federal Security Agency had prepared in 1950 a "model law" entitled, "A Draft Act Governing Hospitalization of the Mentally Ill," there was available to us a statute that could be utilized with only minor changes. This was therefore, almost word for word, the House bill that was made into law by the Utah Legislature one year ago.

The "model law" had not been previously tested in its complete form, though the principles embodied in many of its sections were already in use in other states. It therefore seemed to us that our experiences with it, augmented by what knowledge we could acquire (obtained by means of a questionnaire, which will be discussed below) of the reactions of various groups of persons throughout the state, might be worth reporting to others interested in similar legislative changes.

The previous Utah laws relating to the hospitalization of the mentally ill, were, in spite of their defects, comparatively progressive. At a time (1949) when trial by jury as a commitment procedure was mandatory in one state and optional in 25 states(1), Utah had no such medieval procedure. Commitment of the involuntary patient was effected by an order issued by a district judge based on an examination of the patient by 2 licensed physicians and such other "evidence" as seemed appropriate. The patient could be sent to the hospital either for a temporary observational period of 30 days or for an indefinite period. The presence of the patient at the hearing could be waived if the judge felt it to be inexpedient. Furthermore, Utah provided for an emergency commitment procedure without court order and for voluntary admissions, though there were still states in this country whose laws did not contain these important provisions.

On the other side of the picture, the most important defects of the law were:

1. "Insanity," rather than mental illness, was the basis on which all patients were admitted to the hospital. Commitment of involuntary patients depended upon their being

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

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certified as insane, and even voluntary patients were labeled "cases of incipient insanity." Only alcoholics and drug addicts were immune from the allegation of insanity specified or implied for all other mentally ill persons.

2. Since "insanity" was not defined by the law, the concept of incompetence was used as being synonymous. It is obvious that since the attention of the judge, physicians, family, and patient was focused on this point, the whole procedure took on the coloring of an accusation against which the patient was required to defend himself. Further, as Dunford(2) comments, "We have frequently had medical examiners refuse to pronounce a proposed patient insane, while at the same time they have explained to the Court that they found . . . [mental illness] . . . with insufficient degeneration . . . to bring the proposed patient within the medical concept of insanity. These unfortunates were then left without treatment pending the point . . . where they might qualify for such treatment by being found insane."

3. There was economic discrimination *against* the voluntary patient in that he (or his family) was required to pay the full cost of his hospitalization while the involuntary patient could, depending upon his economic status, pay this amount "or portion thereof." The obvious result was that many who could have been persuaded to participate to some extent in the application for their hospitalization were discouraged by this very realistic financial barrier, and were eventually forced into being committed as involuntary patients. The families of patients were under the same pressure.

4. As indicated above, there was a distinct criminal flavor to all the commitment proceedings. The patient was "alleged to be insane" and the sheriff or constable was given a warrant for bringing the patient before the judge, providing custody for him until the conclusion of the investigation, and transporting him to the hospital. In our experience, the judges made every possible effort to ensure the dignity of the hearings and to protect the feelings of the patient and his family, but the legal framework did not allow them to eliminate altogether the punitive aspects of the situation.

The new law provides specific corrections for some of these defects:

1. "Insanity" has been discarded as a basis for the treatment and/or hospitalization of the mentally ill person. The word "insanity" is not used in the new law at all. In its place appears "mental illness" and a mentally ill individual is specifically defined as one "having a psychiatric or other disease which substantially impairs his mental health." Fortunately, no one has yet insisted that we define "mental health," but this elastic definition obviously lends itself to a medical rather than a legal handling of the problem.

2. The economic barrier against the voluntary patient has been specifically eliminated, and the determination of the pay status of the patient can thus be made after he has been admitted to the hospital.

3. An attempt has been made to eliminate the criminal flavor formerly prominent in all commitment proceedings. Major improvements in this direction are as follows:

(a.) The establishment of a nonjudicial commitment procedure in which the patient can be sent to the hospital on the application of a relative or friend and the certificate of 2 physicians. (Under the law these physicians must be specially appointed "Designated Examiners," a matter that will be discussed later.) This is in accordance with the recommendation of the Committee on Forensic Psychiatry of the Group for the Advancement of Psychiatry(3), and approaches the usual medical consultation procedure seen in any serious illness.

(b.) Even in those cases that require a judicial commitment procedure, the judge is now authorized to conduct the hearing in an informal manner, to exclude all unnecessary persons, and to provide a physical setting not deleterious to the mental health of the patient. In our own experience, the change has been remarkable. Naturally, the total number of judicial hearings has diminished since the nonjudicial method has been available. In those remaining, the hearings formerly open to the public and also attended by the voyeurs and sensation-seekers are now held behind locked doors. In most cases no law-enforcement officer is present.

(c.) Whereas formerly the sheriff or constable was utilized to provide custody for the involuntary patient pending his hearing,

and transportation to the hospital once he had been found insane, under the new law the law-enforcement agencies are used only if the patient has been certified dangerous. The law specifically forbids the detention of such patients in jails or similar facilities, "except . . . [in] . . . extreme emergency," and authorizes the transportation of the patient to the hospital "with suitable medical or nursing attendants and by such means as may be suitable for his medical condition." Practically, this means that the patients are taken to the hospital in the hospital's station wagon instead of in the Black Maria or prowl car.

In addition to these changes from the previous law, the new law provides additional procedures that may be mentioned briefly:

1. *Two forms of emergency commitment.* —First, the medical certification, initiated by any person who states that the patient is likely to injure himself or others, backed by the certificate of any licensed physician stating that he concurs in this opinion, and certified by the head of the local board of health or the judge of the district court; second, the full emergency procedure, initiated and carried into effect by any health or peace officer who feels that the patient is dangerous and must be immediately hospitalized. Both of these procedures require later review of the case by a judicial hearing.

2. *Modification of the discharge procedures.*— The patient admitted to the hospital voluntarily may request his discharge and obtain it immediately unless the hospital superintendent initiates a judicial hearing and the patient is thereby committed to the hospital. Also, the patient committed to the hospital by any of the procedures named in the law may request his release (or a responsible relative may request it for him) and obtain it or a review of his case by a judicial hearing or a special commissioner.

3. *Specific statement of patients' rights.*— While the old law contained the usual prohibitions against inhumane treatment of patients, the new law is extremely specific regarding the rights of patients to communicate by sealed mail and to exercise all civil rights unless they have been actually adjudicated incompetent.

As previously mentioned, the medical examination, which is the sole basis for the nonjudicial commitment procedure, and which is essential to the judicial commitment procedure, is performed by "Designated Examiners." It is obvious that ideally these persons should be qualified psychiatrists. It is equally obvious, as the authors of the Draft Act note in their own Commentary, that variations in the number of psychiatrists available in a given state, or even in parts of a given state, may make such a criterion unrealistic. In Utah where there are only 13 psychiatrists, and these are concentrated in 3 cities, "Designated Examiners" in the outlying areas are simply physicians appointed by the State Welfare Commission to serve in this capacity. We feel that accessibility is more important than formal psychiatric training. This compromise can, of course, be carried too far, as has already been done in the State of Idaho, where clinical psychologists can be "Designated Examiners" (4). A considerable segment of the population fears commitment of the involuntary patient unless there is judicial supervision. The physician may be able to assume this responsibility because of his traditional relationship with his patient but the nonmedical person, however great his professional skill, lacks this traditional relationship. The allocation of such responsibilities to persons other than physicians jeopardizes the entire nonjudicial commitment procedure and emphasizes the all-too-common impression that mental illness differs in some way from other illnesses.

These changes, from the old to the new law, were not effected without some opposition. While there was never any organized attempt to block the passage of the new bill, many persons expressed some doubts as to the advantages to be gained from it. Some were obviously based on misunderstanding. For example, an attorney wrote, "My idea is is that a mentally ill person is insane. Am I right or wrong about this, and if so, what difference does it make?" Others apparently stemmed from a general reactionary attitude that the "old law is good enough; why bother?"

There were 3 specific objections, however, that could not be silenced in advance, since only experience with the new law could pro-

vide adequate answers. First, there was outspoken fear that the new law would lend itself to "railroading," since the nonjudicial commitment procedure did not require a legal certification and the emergency procedures could be initiated by almost anyone and carried forward with the barest minimum of legal certification. Second, there was some fear that the increased ease of admission procedures would further overload the already hard-pressed hospital facilities. Third, it was pointed out that, since the law required that a patient's case could be reviewed on his application for discharge from the hospital, the district court nearest the hospital would probably be deluged by requests for judicial hearings.

In view of these expressed objections, some effort was made, after the passage of the law, to inform interested persons of its provisions and to discuss it with professional and lay groups at every opportunity. Summaries of the law were prepared and sent to all members of the Utah State Medical Society, and a District Judge prepared a critique of the law for publication in the Utah Bar Bulletin(2).

The people of the state, especially those who might be most concerned with the new law, had therefore had a fairly extensive public education program prior to May, 1951, and some additional information had been issued to the two major professional groups after the passage of the bill.

In March, 1952, an attempt was made to correlate our experiences and those of the state hospital personnel with some estimate of the experiences and attitudes of persons throughout the state. A questionnaire was prepared and sent to 187 physicians, 55 public health nurses, 27 judges, 130 lawyers, 42 members of the Women's Legislative Council, and 140 law-enforcement officers—a total of 581 persons. The names were arranged by cities and towns. The first name in each community was used and, where there were a sufficient number, every fifth name thereafter. The returns were somewhat disappointing: Only 41% of the physicians, 69% of the nurses, 52% of the judges, 42% of the lawyers, 67% of the council members, and 31% of the law-enforcement officers, an over-all average of 46%, were sufficiently interested to answer the questionnaire.

The questionnaire itself contained yes-no and multiple-choice questions, with space for comments and suggestions. Care was taken to avoid loaded questions. Though some of the answers tabulated appear to have little meaning, others may be of some value and interest.

The question, "Is a mentally ill person insane?" was answered: Always 2%; Never 6%; Some are, some are not 89%; Don't know 3%. But, "Should guardians be appointed for all mentally ill persons?" was answered: Yes 51%; No 49%. In the face of an apparent overwhelming awareness that "mental illness" and "insanity" are not synonymous terms, the uneasiness regarding guardianship must indicate that the question of competence still looms large in the general attitude toward all mental illness.

A partial evaluation of this attitude was attempted by a multiple-choice question, "What do you think is the main cause of mental illness?" The choices were as follows:

Overwork 26%
Poor home environment 44%
Sinful living 15%
Injury to the head 21%
Heredity 54%
Family and other troubles 74%
Venereal disease 37%
Vitamin deficiency 6%

It would appear that, while many people are aware that "troubles" and "environment" contribute to mental illness, a considerable group is still inclined to associate mental illness with misbehavior of one kind or another, as indicated by the figures for "sinful living" and "venereal disease."

In this comparatively sophisticated group, the persistence of these ideas is surprising, though Steneck(5), in a similar survey in metropolitan St. Louis, found that 3/5 of his respondents felt that mental illness was due to a lack of sufficient will power and ⅓ attributed it to "punishment by God for a sin."

On the specific problem of the new law itself, the question, "Are you familiar with the recent changes in the laws of Utah relating to the hospitalization of the mentally ill?" was answered by "Yes" in 56% of of those responding. Since, as has been previously mentioned, this was a selected group of persons who might be expected to have

some knowledge of the new law (the physicians and lawyers had, through their own professional organizations, received special orientation material), there may be some validity to one respondent's comment that, "Ninety per cent of the people don't know that the law has been changed, or what it is or was."

Those persons who claimed some knowledge that the law had been changed were then asked, "In your opinion, is the new Utah law, as compared to the old: The same? Don't know. Better? Worse?" with the further request that they give reasons for or comments on their answers. Approximately 86% felt that the new law was better than the old. Sample comments were:

Physicians: "It makes nonjudicial commitments possible."
"Admission is more easily and rapidly accomplished."
Lawyers: "More flexible and adaptable to situations."
"Removes stigma of court commitments."
Judge: "Encourages early hospitalization."

A considerable group, however (21% of the judges, 16% of the lawyers, 12% of the law-enforcement officers, and 4% of the physicians, an over-all average of 8% of the total group), felt that the new law was worse. As an additional check on criticisms, we included a question, "Regardless of the opinion stated above, what do you feel is the worst aspect of the new law?" One sour, but quite correct, answer was, "Its numerous typographical errors." The more universal comments included:

Lawyers: "Some potential of danger from misuse and abuse."
"Too damn easy to put a patient in the hospital."
Judges: "Person's rights may be more easily disregarded."
"Opens gate for railroading."
"Definition of mentally ill individual is so broad as to constitute no proper yardstick."
Physicians: "A person can be committed just because his relatives want to get rid of him."
"Will overload existing facilities."
"Physicians, even psychiatrists, are not always either right or righteous."
Chief of Police: "It makes the judge and jury out of the doctor."

This fear of too hasty commitment is undoubtedly reflected in the answers to another question, "Check which of the following procedures would be preferable: Commitment by jury, Commitment by a hearing before a judge, Commitment by a physician's certificate." Some persons checked more than one choice, but of the total number of answers, only 2% selected the commitment by jury. Interestingly enough, 2 physicians and 2 nurses selected this method. While 63% of the total answers indicated approval of the commitment by physician's certificate, there was a good deal of variation from one group to another. The judges (56%) and lawyers (54%) preferred the judicial method, while the physicians (71%) strongly favored the method of commitment by physician's certificate. The law-enforcement officers also preferred the nonjudicial method by 71% of their total response, perhaps because this method diminishes their responsibility for the custody and transportation of many of the patients handled by the judicial procedure.

It thus appears that the persons who answered the questionnaire and who had some knowledge of the new law approved of its principles, with certain reservations and misgivings.

In the experience of the members of the department of psychiatry and the staff of the Utah State Hospital, these misgivings have been largely unjustified. We have noted a very gratifying improvement in our relationships with patients and their families, now that the economic barriers to voluntary admissions have been removed and the commitment of the involuntary patient does not require his being designated "insane" and deprived of his civil rights. It is certainly much less traumatic to the patient and his family to have him examined (often in his home) by 2 physicians and transported to the hospital in a station wagon than to have him subjected to the rigors of a court hearing, however well conducted. This is not meant to imply that the judicial commitment is unnecessary, however; we have been greatly impressed by its value when there are warring factions in a family, and the presence of the judge is often helpful in convincing a family that they have a large share of responsibility for the patient's welfare.

Nor has the overloading of the psychiatric

facilities materialized as some of our respondents feared. A report from the Utah State Hospital comparing the types and numbers of admissions during the period July 1, 1950, to March 31, 1951, with the admissions during the same period in 1951-1952 appears in Table 1.

The total admissions for the 2 periods are essentially equal; though prior to the passage of the new law 66.5% were admitted by court order as compared to 20% admitted in this manner since the new law went into effect. We had expected a rise in the number of voluntary admissions, which actually dropped slightly, and can conclude only that there is not yet sufficient general orientation to effect this change. The increase in emergency admissions from 31 to 85 is also surprising, but is at least partially accounted for by the fact that in some areas there are not yet sufficient "Designated Examiners" to make nonjudicial commitment easily available. Under these circumstances the most efficient method of commitment is one of the emergency procedures. That this does not represent the "railroading" feared by some is indicated by the fact that the hospital authorities have found only 8 of the 85 emergency admissions unsuitable for retention in the hospital. This is actually lower than the "discharge from emergency" rate in the previous year, when it was found unnecessary to admit 14 of the 31 patients sent to the hospital.

As previously noted, there was some fear that the review by a judicial hearing, which was mandatory for emergency admissions, would result in an overloading of court calendars. The total drop in "court order" admissions would obviously indicate that there has been no general overloading. The district court nearest the state hospital carries the burden of the review of all emergency admissions. Even in this court, however, there has been a drop from 27 to 21 in the number of court hearings held during comparable 5-month periods before and after the passage of the new law.

TABLE 1

REPORT OF ADMISSIONS TO THE UTAH STATE HOSPITAL FOR A NINE MONTHS' PERIOD BEFORE AND SINCE THE NEW HOSPITALIZATION LAW BECAME EFFECTIVE

	7/1/50 to 3/31/51						7/1/51 to 3/31/52					
	Regular admissions		Transfers from emerg.		Total		Regular admissions		Transfers from emerg.		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Voluntary	91	28.4	2	..	93	29.0	87	26.8	2	..	89	27.4
Standard nonjud.	..	..	..	..	..	..	100	30.08	62	..	162	50.0
Court order	198	61.8	15	..	213	66.5	52	16.0	13	..	65	20.0
Total regular adms.	289	90.0	..	..	306	95.6	239	73.7	..	..	316	97.5
Trans. from emerg.	17	05.3	17	05.3	..	..	77	23.7	77	23.7	..	..
Disch. from emerg.	..	..	14	04.3	14	04.3	..	..	8	02.4	8	02.4
Total emerg. adms.	..	..	31	09.6	..	..	..	..	85	26.2	..	..
Grand total of completed adms.	306	95.6					316	97.5				
Grand total of admissions					320	100%					324	100%

Certain suggestions and recommendations for the improvement of the law seem to be justified by our rather brief experience with it. We have had some difficulty since the law provides no specific way by which a recalcitrant patient can be examined or brought under medical supervision unless he has been certified to be "dangerous." Even under the judicial procedure, the court may "order . . . . [the patient] . . . . to submit to such examination" but has no specified way of implementing this order. Dunford(2) calls this "the most important criticism of . . . . the act," and the overuse of the "emergency" procedures may be due, in part, to the fact that these procedures are quite clear-cut, though the authorities may have to stretch a point in order to certify the patient as "dangerous." Even after the nondangerous patient has been committed by court order, his transportation to the hospital is simply "arranged for" by the local

health authority with no definite statement as to the powers, responsibilities, and authority of the "suitable medical or nursing attendants" who make the actual contact with the patient.

This is a knotty problem since it clearly involves encroachment on the personal liberty of a person who has not been deprived legally of his civil rights. There would appear to be a good deal of precedent in the protective responsibility the physician assumes for a patient. Certainly a physician who did not at once restrict the physical movements of a delirious patient would be justifiably subject to criticism. The most worth-while suggested solution that has come to our attention is that made by the Forensic Committee of the Group for the Advancement of Psychiatry, *viz.*, that state hospital or clinic personnel might be deputized or delegated for this specific purpose(3).

One other major addition to the law may be advisable: The establishment of some sort of mandatory review of all admissions and investigation of all complaints by a professional authority outside the hospital. The superintendent of the hospital and his staff carry the entire responsibility for determining when a patient is suitable for discharge, and this duty is often made extremely difficult by the unreasonable demands of well-meaning but uninformed persons. A regularly constituted professional advisory board (of the type recommended in a recent excellent critique of the Draft Act(6)) might dilute the responsibility for such decisions and at the same time reassure the public.

Summary

1. The experience of a year with the Federal Security Agency Draft Act incorporated into the State Law of Utah in May, 1951, indicates that this "model law" has distinct advantages and, in general, has proved itself to be efficient and workable.

2. Two major and rather important revisions of the law are indicated:

(a). Provision for some form of legally authorized medical personnel to handle the patient who is not dangerous, but is merely uncooperative, lacking in insight, stubborn, or recalcitrant. These persons would have authority to assist in the examination of such patients and to transport them to the hospital as directed by the appropriate commitment procedure.

(b). A regularly constituted medical authority to review the admissions to the hospital and investigate complaints, thus protecting the superintendent and his staff from the often unjust criticism directed at them and protecting the patients from those rare situations in which there is grossly inadequate care and observation.

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DISCUSSION

Clifton T. Perkins, M.D. (Baltimore, Maryland.)—Dr. Branch has given us a truly objective look at a year of experience with the first attempt of a state to utilize, almost in toto, the "model law" suggested by the Federal Security Agency through its National Institute of Mental Health. It might be well to note again, for emphasis, that Utah's laws concerning the mentally ill a year ago were not archaic or obsolete; that they were generally workable; and that they embodied principles that are common denominators with statutes in many progressive states. But Utah, wishing to lay more emphasis on medical procedures for sick people, chose to cast off its former "good laws" for what it believes will prove to be "better laws."

Certainly the minimizing of "economic discrimination" against voluntary patients as formerly practiced in Utah, and the more informal judicial procedures now utilized, are accomplishments that, in themselves, would seem to justify the new laws. The real big possible danger—"railroading," if there is such a word or act—will show its ugly head in direct proportion to public understanding of what constitutes mental illness and the high-minded purpose of the individual physicians who participate in the commitment procedures.

To me, the most important feature in this whole presentation is not found in any single paragraph

or statement, nor is it to be found alone in the remarkable survey of thoughtful people that is reported. It is threaded throughout the entire paper. It constitutes an improved public understanding of mental illness—an improved public attitude toward the mentally ill. And where that understanding and that attitude are right, as they seem to be in Utah, we can look forward to good and progressive steps being taken for the mentally ill. Such understanding and attitudes come only from long, tedious, and too often from seemingly unrewarding efforts at public education. In Utah that process of education and public information appears to have started well in advance of the promulgation of the new statutes—which, I suspect, is a major reason why they have run into so little opposition and why the law has been so successful in its first year of operation.

I would like to emphasize one other point that has to do with psychiatric education and that, at least obliquely, may be related to the subject of Dr. Branch's paper. As an administrator of public medical services (and the care of the mentally ill anywhere in this country falls generally into that category) I feel very strongly that administration is a very important therapeutic agent—or at least it should be. And that means the administration of laws, and the changing of laws. Dr. Branch has mentioned how changes in laws seem to have improved the total medical concept of mental illness in Utah. Because of the very nature of many forms and degrees of mental illness, it is probable that for a good many years to come the mentally ill will have to be surrounded with more protective laws than those ill persons who have only the more obvious physical handicaps. It seems appropriate to suggest that formal education in psychiatry, at both the undergraduate and the graduate level, include a more thorough indoctrination and understanding of the newer medico-administrative and medicolegal procedures. It would afford the best guarantee that the next generation of doctors, through better understanding of the importance of both legal and medical implications, would not abuse or handle lightly the important laws relating to sick people.

Finally, I would like to suggest that the National Institute of Mental Health or some other appropriate agency be given authority to cause reprints of this paper to be placed in the hands of those responsible for administering similar services in the various states and territories.

USING LEISURE TIME AGENCIES TO TREAT THE PROBLEMS CONFRONTING ADOLESCENTS [1]

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Boys' clubs, settlements, neighborhood houses, and playgrounds, which attract so many adolescents in their after-school hours, present the psychiatrist with an ideal setting for a natural history study of family life and for observing youth's daily struggle with the total environment. There is no other setting in our culture where adolescents and their families go and come as they please, where the door always remains open and no superimposed artificial pattern prevails such as obtains for the school situation. Because the free and easy come-and-go within the leisure-time agency comes closest to a natural habitat, a sensitized observer has a marvelous opportunity to discern the intrafamilial and extrafamilial formative relationships. Thousands of youths in metropolitan areas throughout the country have more sustained contact with the personnel of leisure-time agencies than they have with their own parents, and at a time of life when such contact has a particularly high formative value.

Psychiatry and psychoanalysis have moved into the home and also, to a lesser extent, into the schools, but the great leisure-time field has been seriously overlooked. From the intensive study of man under neurotic and psychotic stress, psychiatry and psychoanalysis have gained significant insights into the dynamics of human behavior and motivation and particularly into the formative significance of interpersonal relationships. We have thus an indispensable contribution to make to the training of leisure-time and recreation personnel for which our services constantly are being sought. But few psychiatrists have had any experience in the community and so, before we can fulfill this particular teaching function, psychiatry must descend from its clinical ivory tower, and through down-to-earth experience with the everyday problems of everyday individuals acquire a language and an approach that is acceptable to the personnel of such agencies.

I have had the good fortune of working in the boys' clubs of the Children's Aid Society of New York City for over 15 years. Functioning as a program advisor, I attended the clubs' playgrounds regularly and spent several hours a week with children and staff. All this experience came to me after 11 years in psychiatry, and 2 years in psychoanalysis. I regard such experience of the greatest value to the practicing psychiatrist and psychoanalyst, and when it comes to health-promotion psychiatry (mental hygiene), such experience proves indispensable.

Leisure-time agencies primarily aim to promote the health of all club members. Therapeutic clinics, comparable to mental-hygiene clinics, which focus upon individual "cases," have no place within a boys' club or settlement house. The procedures adopted by such would carry implications to the members and the community that would alter the whole meaning and function of the agency. Leisure-time agencies are also interested in promoting the healthy growth of the whole being. Medicine has made great strides in determining what is physically essential for healthy growth and what is physically harmful. However, there are also interpersonal elements essential and interpersonal elements harmful to growth, and yet little has been done to define, describe, and translate in terms of everyday living just what these essential and harmful interpersonal elements may be.

This particular psychiatric approach then has as its fundamental objective the inservice training of leisure-time personnel, to create a health-promoting "climate" in the agency that will affect *all* boys and girls. Emphasis throughout is placed upon the cultural and interpersonal factors that determine character, rather than intrapersonal instinctive factors. Greatest emphasis is placed upon the extrafamilial factors. This refers to the "figurative parents" that make up the personnel of the agency. By becoming aware

[1] Read in the section on Child Psychiatry at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

[2] Chairman, Committee on Leisure Time Activity of the American Psychiatric Association.

of their own attitudes and by providing those that are essential and eradicating those that are harmful, personnel can have an influence upon children equal to that of parents. Due consideration is given to the tremendous importance of the intrafamilial factors. However, it must be strongly emphasized that the prevailing tendency to believe that parents are 100% responsible for the character formation of their children has not only demoralized parents, but has also insidiously and profoundly demoralized the agency staff. Given a poor home with maladjusted parents who are completely inaccessible, and unamenable, there is a tendency for personnel to throw up their hands and say, "There is nothing the club can do for those kids." In so doing, they deny their potentialities and their work therefore with children can have no meaning.

General Principles in the Sensitization of Leisure-Time Personnel

The "climate" of the agency depends upon the personnel. Relieving anxiety and promoting morale of the staff become our first consideration. The first step to improve staff morale is to develop in them a sense of their value and an awareness of the tremendous potentialities of their everyday relationships with children. The second step is to give them a clear concept of their function. We should try to define and redefine function in relation to everyday, formative relationships. In my experience, the best work is done when staff are able to conceive their function as that of protecting young people from extremes. The implications and significance of this definition of function—*to protect young people from extremes*—will become clearer as I proceed. The third step to promote morale is to give staff a comprehensible philosophy that enriches the meaning and value of their everyday work.

A philosophy that we found conducive to high personnel morale and an invigorating "climate" has the following constituents: Holism, Humanism, Homer, Humor, Humility. This came to be known as the 5-H Formula.

Holism supports the belief that, in all action and reaction, movement of the whole being precedes movement of any individual part. This assures an approach to the individual and to the group as a whole—and concern for total development. The concept of integration, so helpful in our understanding of personality, should be extended to the social body. Just as the heart is a unique but integral part of the human body, so every youth should be seen as a unique but integral part of the social body. No one item of behavior, no symptom, and no individual can be isolated and singled out for concern, but his whole context of living and the constellation of his various relationships, intrafamilial and extrafamilial, must be kept in focus.

Humanism implies an acceptance of the universality of human nature, and a respect for our beginnings, backgrounds, and foundations. Also, a realization of the past in the present and the present in the past, in accordance with the motto, "The more it changes, the more it remains the same." Humanism affirms that Bastian's law—ontogeny repeats phylogeny—holds not only for structural, but for all phases of human growth. It develops along with interest and training in the humanities and arts. It restores our ability to use creatively our leisure time, which has suffered greatly from a pernicious disease of the social body called technocracy. This is a deficiency disease, due to an unbalanced educational diet that has overemphasized the technical sciences and has neglected the humanities and liberal arts.

Homer is a reminder that, in the evolution of language, poetry came before prose—that children first think metaphorically and not literally—that to the young club member, for example, the club doorkeeper symbolizes all the doorkeepers in song and story rolled into one, including St. Peter. We should appreciate the universal themes that express themselves in human nature and recognize the poetic in everyday situations and incidents, as for instance—the profound poetic implications of a brother-keeper relationship. We should think figuratively about children and take much of what they say figuratively, as well as literally. When, for instance, one adolescent constantly complains that he is locked out of the games room, and another always wishes it wasn't so cold in the club, they may be talking more about their interpersonal world than their physical world.

Humor gives us the ability to laugh at

the juxtaposition of opposites in ourselves and to recognize and accept, but not condone, our inconsistencies and contradictions. The ability to admit these inner conflicts assures our superiority over them and lessens our tendency to overreact to the idiosyncracies of others.

Humility ensures an acceptance of human frailties, contradictions, and limitations and a healthy, warm affection for the early groping, fumbling beginning stages of social development. It helps to preclude making implicit and explicit excessive demands upon ourselves and others and the setting up of excessive expectations. It increases the capacity to love the child in oneself and is part of the humanistic approach.

Along with the above general principles, there are 10 *specific guiding principles* that are effective in this inservice training.

1. In growing up, the following interpersonal conditions present challenges or problems to the young individual: (a) a deficiency in those human attitudes helpful to growth and/or (b) the presence of human attitudes harmful to growth.

2. *All* adolescents have such problems. Since we are human, there can be no ideal family, no ideal leisure-time agency, no ideal "home from home" but only the striving for such. Because of the anxieties of present-day living, adult attitudes present youth with challenges and problems. Challenge is perhaps a preferable word to problem and perhaps the term problem should only apply to extreme challenges. There may be considerable disagreement as to the kind of adult attitudes that represent challenges and problems. The late James Plant posed the question, what are the 18 or 20 problems that are common to the children of our culture? We can say that overprotection, rejection, exploitation, deprivation, male preference, erratic discipline, inconsistency, unpredictability, conflicting and diverse standards, and broken homes are parental attitudes or patterns that can be detrimental to healthy growth. We cannot take these challenges or problems from our children, nor would we want to, because, in adapting to them, children develop their various personalities, temperaments, and dispositions. We can, however, limit and reduce their intensity.

3. There is a universality about such challenges. That is, they differ in degree and not in kind, as we pass from one family to another, from one economic level to another, from one racial group to another.

4. Children show an amazing degree of adaptability in their experimental efforts to cope with these various interpersonal attitudes.

5. All children will naturally grow straight unless something in their interpersonal contacts makes them grow crooked. When that something is removed, they will grow straight again.

6. It is not the challenge nor the problem *per se*, but its intensity that leads to and necessitates extreme deviation.

7. The adolescent is the sensitive indicator of the presence of an extreme problem. Antisocial, deviated behavior—unusual behavior either of a positive or a negative nature—are symptoms, indications, signals that some extreme challenge confronts him.

8. All behavior is purposeful. Much of a youth's behavior represents his often-conflicting conscious and unconscious attempts to resolve such problems and challenges *so that* healthy growth can proceed. Personnel frequently confuse what could be called the primary problems, as mentioned above, and secondary problems. Secondary problems are those problems created by the youth's behavior, for example, truancy, delinquency, overaggressiveness, extreme shyness, etc. These are some of the common deviations resorted to in youth's experimental attempts to deal with extreme primary problems.

9. *Diagnosis of problems should precede diagnosis of the adolescent.* This point of view effects a great change in the whole attitude of the agency. It shifts the focus of attention from the adolescent and obviates all finger-pointing, comparisons, and singling out of individuals. It surely is obvious that a basic orientation around the problems of adolescents is preferable to that of an orientation around problem adolescents. Personnel qualifications should be evaluated not in terms of understanding youth but in terms of understanding the problems of youth.

A basic requirement of personnel in a leisure-time agency would be to acquire some awareness of the problems of youth. As mentioned above, these are universal and only

differ in degree, and not in kind, for each individual; but by studying their manifestations in everyday work and contacts, the personnel will become sensitized to their existence and their local prevalence and intensity. Psychiatry and psychoanalysis have shown us the extent to which blind and insensitive individuals (albeit with good intentions) can unwittingly and inadvertently aggravate and perpetuate not only these problems *per se* but many of youth's unhealthy attempts at solution. Sensitization of staff to the problems that confront all children will enable them to follow the final guiding principle and ensure protection of young people from extremes.

10. Avoid the unwitting, inadvertent, or unconscious perpetuation of (a) the problems of these young people and (b) their unhealthy attempts at solution.

The whole idea of unconscious and inadvertent perpetuation introduces a new and significant dynamic concept. It helps to direct our attention to what we are doing unconsciously (habitually, "without thinking") in our immediate contacts. Also, the extent to which we unknowingly complement one another's behavior patterns and the unhealthy nature of many complementary relationships (for example, the possessive parent and the dependent child). There has been an overconcern with genetic causes—and overemphasis upon what initiates the intense problems and challenges of youth—and not enough emphasis on what keeps these problems alive.

The following is a helpful train of thought. The parents of the growing child do initiate problems because of their unfavorable anxiety-driven attitudes. If these are not too severe, the child's natural adaptability will find a way of overcoming the unfavorable climate without serious deviation, so that its natural growth and self-expression can proceed. However, during preadolescence and adolescence, when the child begins to leave the home more frequently, a blind and insensitive culture can intensify and aggravate unconsciously and even consciously the problems that originated in the home and the unhealthy attempts at solution. Then, as the final step in the whole process, the individual begins unconsciously to perpetuate his own difficulties and his own unhealthy solutions.

Therefore, to our list of causes, genetic causes, contributing causes, precipitating causes, we must now add *perpetuating* causes. When a staff worker asks, "What should I do with this child, or with this group?" we have to say, "Let us try, first of all, to find out what you are doing, because, obviously, what you plan to do today or tomorrow is predicated on what you are doing right here and now."

We have made great contributions toward helping individuals recognize how they are unconsciously their own worst enemy—how they set up their own obstacles to growth—and unconsciously perpetuate their own difficulties. Now we must help individuals to realize how and when they are unconsciously perpetuating the problems of others that consciously they strive to remove.

METHODS OF SENSITIZING STAFF

The fundamental principle here is to remind personnel rather than to inform them. Many are completely unaware of the valuable knowledge they have accumulated over the years about significant interpersonal patterns and formative relationships. Sensitization aims to awaken what exists but remains unconscious and is best expressed by the phrase, "He who knows and knows not he knows, he is asleep—wake him." The activation of this latent knowledge has the most amazing effect upon the morale of personnel.

Staff are encouraged to define and describe the attitudes favorable and unfavorable to human growth. All will agree that "perfect love casteth out all fear" and that love and affection are the essential ingredients of a healthy climate, but in everyday work it is essential to translate these abstracts into what you should actually do or give, in the everyday relationships. It is much easier to say what is not love than to say what is love. But, more significant still, great self-deception arises in this regard since many attitudes are mistaken for love and affection that turn out to be the exact opposite. I have in mind here overprotection, possessive love, and exploitation of the individual. Staff are not only deceived by such attitudes, but at first they glorify and defend them as virtues.

Personnel are led to extend their interest beyond the individual, to focus their attention not so much upon what is going on inside the individual but what is going on be-

tween individuals. Where previously there had been concern for the anatomy and physiology (structure and function) of the *human* body, there is now concern for the anatomy and physiology (structure and function) of the *social* body, along with the encouragement to see the individual as a unique but integral part of the social body. The constellation of the social body, the family pattern, the club family pattern becomes important. Positive and negative trends and attitudes within the social body become the field of consideration and always the observer is helped to see himself as a functional (*e.g.*, complementary and perpetuating) part of what he is observing.

Staff are encouraged to examine their own childhood and adolescence and compare the various problems that confronted them. From this and their daily experience in the agency, there comes a keener awareness that the uniqueness of the problems confronting growing individuals stems from a difference of degree, from a unique arrangement and blending of common human attitudes. Sensitization to these common denominators in our lives that make us all akin assists freedom of expression and ventilation of individual problems, and converts discussions and conferences into true democratic processes.

There is a need to support this program of staff sensitization with something of a practical, technical nature. Given the orientation indicated above, staff are able to make many pertinent, significant observations about adolescents and their problems in the course of their work in the playground, games room, gymnasium. However, to this sensitized observation should be added an interview with individual children. The purpose of this interview must be fully grasped. *It is not carried out to help diagnose the adolescent but to help diagnose the problems to which the adolescent may be exposed.*

Leisure-time agencies should take regular and frequent samples of the culture they serve, in order to keep aware of its favorable and unfavorable ingredients. Since children are sensitive indicators, examinations of different club members will yield valuable cultural samples for analysis. As with any examination, we must adapt our instrument to the sensitivity of what we are examining.

In our program, we have been using a special indirect questionnaire. Years ago, Dr. Adolf Meyer believed that the indirect questionnaire was one of the most effective means for eliciting reliable information about interpersonal relationships. This present questionnaire, which is an improvement on the one first reported in 1939 [3] required great care in preparation. Acceptability of the interview to the everyday club members had to be assured. We made certain that the words, phrases, and the form of the questions were typical of the language of the club area. The questions were identical with those that we had heard children ask of each other. Acceptability was further assured when the young people knew that everyone was to have an interview and that the material elicited was to be used to improve the policies and program of the club, so that everyone would get more satisfaction from participation. One great proof of the acceptability of the interview to the members and the community has been the fact that, although over 3,500 children have been questioned, their relatives have never complained or objected or become suspicious or apprehensive. This is of particular significance when we remember that these less privileged areas, more than any others, are constantly under the eyes of the law and the families therein have every reason to be suspicious, apprehensive, defensive, and to resent inquiries of any kind.

The role of the interviewer is that of program advisor and not psychiatrist. The interview takes place in a place chosen by or acceptable to the club member, *i.e.*, a workshop, games room, temporarily vacated, which has pleasant associations. Children are selected at random. No one adolescent is singled out because he presents some unusual deviation. In the general sampling taken, some deviated individuals may be included, but this is in no way the purpose of our questioning.

This brief interview has proved to be a reliable means of determining certain predominant parental attitudes and intrafamilial problems confronting each individual. In most instances, the youngsters' comments indirectly revealed significant parental attitudes that had been completely overlooked. The picture of intrafamilial relationships that was constructed from the youngsters' an-

[3] Martin, A. R. Psychiatry in the boys' club. Am. J. Orthopsychiat., 9: 123, Jan. 1939.

swers was very often in striking contrast to the picture of the family life that the staff had formed from their contacts. After the staff had been sensitized by the interview, many family situations that had formerly been accepted as healthy were recognized to be quite unhealthy and found closely to conform to the interview picture. Thus, our work demonstrated the great extent of our misinformation and real ignorance as to each individual's personal world, because so many of us, irrespective of experience, had subjective, emotional "blind spots" for certain significant parental attitudes until the interview brought them to our attention. This sensitization was usually signalized by a statement from staff such as "Now that you mention it, Doctor, I can see what the boy has been up against."

As we became more expert in diagnosing the youngsters' problems from the interview, we found that we were more inclined to err on the side of not attaching enough significance to what was said. Much more valid data were gained from a boy's response to indirect nonleading informal questions than from his mood and behavior during the interview. Much of a boy's behavior represented his attempts to deal with the intrafamilial problems that we sought to uncover, and we were primarily interested in diagnosing each boy's problem and not in diagnosing the boy.

The wealth of material provided an excellent opportunity for an extensive comparative analysis. This served clearly to reveal similarities and differences in the parental attitudes confronting adolescents and brought many problems to light that otherwise would have passed unnoticed.

The universal occurrence and the similarity of intrafamilial problems was borne out by every interview. From my experience in New York City, with the American Negro, West Indian Negro, Irish, Czechoslovak, and Southern Italian groups, I was always aware of quantitative and not qualitative variations. In Harlem, for instance, overprotection of the young male child is relatively rare, whereas in the Southern Italian section this is the rule. Similarly, preference for a male child is less marked in the metropolitan American Negro than in other metropolitan racial groups.[4]

Familiarity with these fundamental and universal problems enabled us quickly to recognize their familial and racial variations and intensities. Furthermore, it seemed clear that a boy's behavior was more directly related to the intensity of his problem than to its nature and much of his behavior represented the various strategies and maneuvers that he had found, in the course of his conscious and unconscious experimenting, would bring him the greatest relief or the best solution. Urgent, intense problems made the boy more compulsive and indiscriminate in his choice of solution and invariably produced extreme behavior. Even in those instances where parental attitudes were very severe and were obviously having a marked effect upon behavior, the boy showed no awareness of what was really troubling him. No boy at any time verbalized his intrafamilial difficulties or his basic problems. These were all revealed indirectly during the interview and subsequently confirmed.

I discuss these interviews with staff individually and collectively. Each conference can be seen as a kind of dissection procedure during which we endeavor by the study of the interrelations in one social body to learn something about social bodies in general.

Special thought was given to 4 major problems that we found were the most prevalent harmful parental attitudes throughout the metropolitan area. This classification was purely arbitrary, and represented an initial attempt to diagnose common conditions of living. The 4 commonest parental attitudes were rejection, deprivation, overprotection, and exploitation. Staff became especially sensitized to and conversant with manifestations of these problems in the lives of young people. Particular care was taken insofar as possible in the club family, in the home from home, that there would not be in the policies and programs and the interpersonal relationships the perpetuation of any of these attitudes.

As the staff acquire by these various means a greater awareness of the problems in their

[4] Martin, A. R. Study of parental attitudes and their influence upon personality development. Education, 63: 596, June 1943.

own lives, and the problems in the lives of children, they become better equipped to carry out their greatest function, that of protecting children from extremes. Only by constantly thinking and working in terms of these everyday problems that confront all of us can staff be more and more certain that they are not unconsciously perpetuating the unfavorable attitudes and relationships which, not by their existence, but by their intensity alone, can bring about serious deviations in the growth of the individual.

Outline to be Followed in the Interview with Club Members

At the outset it is important to know what you are setting out to discover from each boy or girl. You start with the assumption that all children have challenges or problems and the important thing is to find out those that confront each interviewed youngster in his everyday relationships. He does not verbalize his challenges or problems nor does he ever think in these terms. Some problems will be more marked than others; they will overlap but it is possible to get some vague idea of the important attitudes that confront each individual in his growing up that affect total growth.

1. The youngster should be made to feel absolutely at ease. This is an informal conversation. Keep the same questions in the same order. They have to do with the everyday life of the youngster in and around the Club and with his companions. At the outset you should not address any questions to the youngsters. When I interviewed I first of all told them who I was, I indicated the chair where they were going to sit down and then I would point to my chair and say "I'm going to sit down here," then I would say "I have been coming here a long time and I'm sure I know a great many of your friends. I am helping Mr. K or Mr. L to improve the program, to bring more things here to the Club and add more things to the program so that all of you people will have more fun and get more satisfaction here," the principle being that in all first contacts something should flow from you to the individual. Every question after all is a demand regardless of the friendliness of that question and regardless of how pleasant the topic may be.

2. Everything that boys or girls say to you has value. Many are speaking figuratively. Certainly take them literally but consider what the possible figurative implication may be of what they say. For instance, when a youngster keeps complaining about some of the doors being locked in the Club it may be that he is telling you that he always feels locked out, that he always feels excluded, that he is hungry to be on the inside, that he really lives in a cold world.

3. Avoid leading questions. There is no need to wait to get an answer to each question. Go right on to the next one. Always get the youngster's first remarks because whatever is uppermost in his mind will come out first and must be there for some reason.

The following are the questions I have asked over 3,000 boys and girls. In the first year I was perfecting this whole procedure, eliminating those questions that did not seem to elicit much of importance, and retaining those that seemed to be particularly revealing.

Questions to be Asked Only After the Interviewer Has Introduced Himself

Do you belong to this Club?
How long have you belonged?
Are you glad you joined?
Why did you join the Club?
What other reasons for joining? (This question should be exhausted. I have always asked "What other reasons?" until the child has told me practically every reason that he could think of.)
What does your mother want you to do here at the Club?
What does your father want you to do here?

(At this point I ask the child his name, address, and school grade.)

Do you know many boys at the Club? (If it is a girl you ask first of all, "Do you know any girls?")
Do you know any girls?
Have you plenty of friends here at the Club?
How often do you come?
What is the first room you go to?
What other room?
What other room? (Here again this question is exhausted.)

(*Note there are no leading questions up to this point.*)

Here you can ask specifically if some room has been omitted. For instance,—Do you go to the gymnasium? Do you go to the Art room?, etc. Or, Do you go upstairs?

Do you play outdoors?
What do you do outdoors?
Do you play any ball game?
What do you like to play best in the whole Club?
Are you on a team?
Would you like to be on a team?
Are you a good boxer?
Are you a good runner?

(The above questions pertain to boys. Regarding girls you say—Do you like to sew? Are you a good sewer?

Are you a fast runner?
Is there anything you want to learn here at the Club?
Is there anything you want to practice at the Club?

The important thing is that you are informal and conversational. Anything the child says spontaneously is extremely valuable. I have found it advisable to write everything that is said in their own words and explain that I do so because then I can remember them when I read it later.

Do you like school?
Well, I mean do you really like it or just half and half?
What do you like best at school?
What else do you like?
What is hardest for you?
Some of these days you're going to grow up and leave school. What would you like to be when you grow up? (Sometimes to this children will say "I don't know" and I've always said "Well, I know you don't know and you will probably change your mind a good deal but tell me some of the things you've thought of.")
What else have you thought of?
What else? (Exhaust this as far as possible. Sometimes it's helpful when the child says "I don't know" to ask them to guess.)
What does your mother want you to be when you grow up?
What does your father want you to be?
Do you have a report card at your school?
What do you get on it?
Who cares about that?
Do you have any homework?
Do you need any help with your homework?
Who helps you?
Who do you live with?
Who else?
How many brothers and sisters have you?

From these questions pertaining to the families some very important attitudes can be disclosed. Get the age of all brothers, and find out what grade they are in at school. It often happens that the child will answer these questions very rapidly—in other words, has a clear awareness of what's going on. Other children are confused about their home relationships.

Who do you have the most fun with in the family?

Then I ask this for each brother and sister and the father and mother—

What's the most fun with Georgie?
What's the most fun with Sarah?
What's the most fun with Sadie?
What's the most fun with your mother?
What's the most fun with your father?

According to the child's position in the family, you say "You are the youngest in the family. How do you like to be the youngest?" "—the oldest?" "—the second?" "—the middle one?" etc.

Do you play with your mother?
Do you play with your father?
Who do you go out with the most?
Where do they take you?
Are you healthy and strong?
Does your father think you're healthy and strong?
Does your mother think you're healthy and strong? (If the boy says "Yes," then you ask—"What does he say about that?" or "What does your mother say?")
Are there any questions you want to ask me about the Club?
Any other questions?
Are you having a good time here?
Is everybody good to you?
Everybody?
Do you ever go to camp?
What's the most fun at camp?

This concludes the interview. Then I say "Well, now I know some of the things you want to do here. You know everybody is different. Some boys like to do some things, some boys like to do something else. Everybody's different and we want to have many things going on here at the Club so that each of you boys and girls can find something that you like to do, and want to do."

CONTRIBUTION OF THE PSYCHIATRIST TO THE MANAGEMENT OF CRISIS SITUATIONS[1]

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During the Second World War, a group of advisers to the different army headquarters in London constituted itself an Inter-Allied Psychological Study Group, to discuss common problems in times of emergency. Although I have been invited to give a report of my experiences during the last war, the points I am about to relate must be looked upon as a result of that very inspiring teamwork. In that group psychiatrists, psychologists, and sociologists worked together. Amid the tensions of that period, to which flying bombs contributed from time to time, the cooperation was nearly ideal.

We came together, not only to exchange experiences, but also to find mutual aid in problems that proved often too difficult for our actual knowledge of facts. We had been asked for advice on questions in which we were not experts at all, while in straight professional circumstances our expert knowledge was many times denied. That often cut both ways. At the end of the war, with its confusing aftermath, there was a greater tendency to ask the psychologist for advice.

Only gradually have we found our way through methodological quandaries, although several mistakes were made either by too pedantic action or by lack of restraint. I want to give a survey of what we thought our most practical function in crisis situations to be. One thing especially we tried to prevent: the compulsive scientific attitude with its use of sophisticated words. I remember so well an official discussion on the morale of the troops—an urgent problem during a certain phase of the war—when we clinicians were pinned down by typical laboratory scientists, who by dint of learned arguments convinced the officials that they should deliver 200 monkeys to them, so that the exact experimental answer could be given after a couple of years. The government official is easily seduced by technical verbiage. The higher his degree of noncomprehension, the more his veneration for the scientist increases. There is also a group of psychologists that denies that the historical and actual reality of man is the most conclusive experiment of all.

Which are the practical points, constituting the bill of goods, we psychiatrists can sell?

1. *Our Psychiatric Concepts of Fear, Emergency, and Catastrophe.*—The newer psychological concepts of panic and catastrophe can clarify the thinking of governmental officials in charge of disaster prevention. Politicians and generals prefer to think in terms of the potential power of the enemy or of the enormity of the outside danger. They are always battling against imaginary ogres. The psychiatrist, however, thinks of the individual man and his fears. What do we learn about man in times of stress? Is man able to bear his actual world? What are his limitations? What happens to him when he breaks down? How does his mental failure influence his fellow beings? Where and why are the individual wheels in the human organization going awry?

We think in terms of first aid and of individual therapy of victims. However, we observe at the same time that other aspect of our work: the collection of new data in order to improve our knowledge of man. Every emergency is a kind of new psychopathological experiment, raising new questions and giving new answers. If we do not stick to this attitude of inquisitive observation, we shall never correct our tentative and premature answers.

In the last war more attention was given to research than during the First World War. In the spring of 1945 our group was able to organize a conference to discuss the different techniques of studying the problems involved. The general opinion was that not enough opportunity had been given to "field-

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

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work on the spot." In a world of growing organization and planning one has to become more conscious of the rôle of the individual in the complicated social machine.

2. *Our Clinical Approach.*—As psychologists and physicians, we have developed a special pragmatic approach to unsolved problems. The clinical approach means working with problems that are not yet scientifically solved. The clinician is able to use a body of historical experiences, yet without knowing the rationale. This must be a horror to the laboratory technicians. The clinician gives a tentative answer, though he is aware of his limits. Quinine and aspirin were used long before we knew their pharmacological rationale. The same approach is valid for our psychological advice in an emergency.

Our clinical-psychological approach implies that we give attention to hidden motivations behind the spoken or printed word. We often give great importance to the faulty suppositions of the observer. We are more aware—than the official strategists—of our own subjectivity, of transference and counter transference. We are trained to observe small signs and symptoms and can show, again and again, that there are far-reaching unconscious motivations. Many so-called logical deductions and discussions may be the cover-up of confused feelings. This, our awareness of the unconscious, is part of our clinical competence.

However, when asked to be a public advisor, we need the greatest tact and restraint. Infantile professional feelings of omnipotence are just as dangerous as compulsive doubt. Yet, clinical objectivity is not always loved. Once, advice was asked regarding a daring strategic manoeuver in occupied Europe. The plan was absurd, indeed, and some obvious pathology possessed the originator, who acted out some neurotic destructiveness at the cost of many young lives. It took several conferences to convince the other officials of these facts and it aroused much hostility toward the psychological advisor. Just as in straight psychoanalysis, we must be careful with our diagnostic insight, until the right time for interpretation has come. In the higher echelons of political life we find such varied neurotic patterns that we might be easily seduced to start a kind of wild psychoanalysis, increasing the confusion and the resistance, of course.

Even for our simple clinical approach we often have to fight. It happened that our advice was asked about what to do with a children's refugee camp that had gone haywire. Our advice to send an available team, consisting of a pediatrician, a psychologist, and a psychiatric social worker, with enough power to reorganize the camp, was not followed. In this case the concerned official had expected the usual desk report from an omnipotent all-knowing committee. Our obvious advice could not satisfy the administrative machine and its hunger for reports.

3. *Our Individualizing Therapeutic Approach.*—The psychiatrist uses the individual approach to the problems of man. Individual needs are so easily forgotten in official mass regulations. Behind masses and groups, there is always the individual being with his personal and paradoxical reactions. As a matter of fact this position had to be defended in our report on "Psychological Problems of Displaced People"(5). We warned repeatedly against so-called "parcel-politics," in which human victims are treated like postal packages, as numbers, without a soul. Such management arouses rebellion and aggression, as was later experienced in several Displaced Persons camps.

In fighting for this right of the individual approach, we had to grind some axes. The nonpsychologically educated authority has the tendency to counter mental problems with an aggressive self-defensive attitude. We had already experienced this in the treatment of battle neurosis by nonpsychiatrists. The same is true for the manner in which some civilian authorities seek to handle panicky populations, by threatening them, bossing them, and so forth. In their latent panic—as a result of panic contagion—they mobilize their own aggressions, not in order to appease the situation but to calm themselves. Let us be truthful: so, despite our knowledge, do we. When I was asked to go as advisor to a commander, who was in a rather panicky mood as result of false rumors, the commander began to rave and speak punitively using me as a welcome scapegoat; so I began to rave in return. However, when I calmed down, a lucky brain wave bid me ask him

if I could measure his blood pressure. That form of magic did the trick; from that moment on we could do business.

In the treatment of battle neurosis and panics, our own anxieties may do much harm and may prevent ready control of the symptoms. Our science has enough data available to prevent panic, or to minimize the emotional reactions in children, or to give sound advice about the evacuation of populations, but all this can be spoiled by our own anxieties.

4. *The Need for Investigation.*—The clinician, before advising therapy, must have a diagnosis. In order to arrive at the diagnosis, he requires a thorough investigation. The psychiatrist who becomes an official advisor will be astonished at the number of authorities who are opposed to such investigation. Strategical problems of management of the public are too often solved behind the desk in a rather prejudiced way. Beautiful words and national slogans seem to be more important than the actual and objective study of the problems involved. We have repeatedly to defend our point that clinical fieldwork is possible, and that, before advice is given, we want to send trained fieldworkers to the spot. In our request for investigation, we will encounter unexpected difficulties. The more a regime becomes authoritarian or totalitarian, the more it shuns such objectivity. In our call for investigation, we will have to compete with tough red tape, with compulsive bureaucracy, and with various self-made experts, like journalists and lay-psychologists. However, at the same time, we have to understand how in the midst of an expanding complicated civilization the very word "bureaucracy" is often used to cover up our unwillingness to join wholeheartedly in governmental teamwork.

Our problem will be to endure and to handle those different tendencies. Often restraint and modesty will be more helpful than scientific pride and aggression. When we were sent as experts to an enquiry on traitors, the psychological aspect of this problem was completely omitted. The jovial prime minister of one small country had no inkling of any psychological motivation. After the session he asked us to take care of his finger, which he had injured that very morning. We did not object to the discussion nor to the required surgical treatment. Yet, 3 weeks later we were asked to make up the report ourselves.

I stress this example because we have to be prepared for such odd experiences when we expose our profession beyond clinical circles. Psychological involvements are likely to be denied. Not long ago an official article appeared in the *Journal of the American Medical Association* denying psychological involvement in civilian defense and atomic war (4; see also 1). Instructors in first aid still stick to their old pattern of bandaging and fracture repair, omitting any psychological advice.

When the problem of collective pathology is touched on, the ranks are even more divided. Politicians are afraid of psychology, though they like to use its terminology as a weapon. There is much pathology in the higher regions of politics, where pride and prejudice fight with power and ignorance. Delusions of omnipotence are not seen only in our patients. Mass emotions and their impact on individuals are underestimated. The bogey of fear and suspicion in a divided world is building greater fear. Primitive patterns of actions more and more determine the course of events. Even when psychologists and psychiatrists have a common front, their voice will have almost no appeal. Our hope lies in a gradual penetration of education with simple sound psychology.

5. *Our Wish to Actualize a Conflict.*—In opposition to some diplomatic methods of disguising and delaying the solution of conflicts, modern clinical psychology advises raising the issue at once, and, when possible, solving it at once. Each delay in solving a conflict, or the effort to cover it up, increases hidden tension and aggression and the chance of an explosion. It is unrealistic to expect a good solution from Father Time, or to be dependent on hidden mental chain reactions. This sounds like the overoptimistic, old Coué formula. Time does not heal wounds, it only conceals them.

In one army command, the wrong course of events was tolerated, though it was known that one of the commanding officers had thereby spoiled a useful strategy. "One," the big vague "one," hoped the best of it.

When our advice was asked about the growing internal tensions in that group, it was difficult to put a finger on the right cause. Not until we could prove that the key man in question had suffered a stroke, were we able to circumvent personal pride and personal involvements.

The consulting psychiatrist will meet many such difficulties because of this cover-up strategy. The mental hygiene of leadership is just developing and, though many officials are convinced of the ominous role of neurotic and psychopathic leaders, it will be a long time before sound psychology will be allowed to test the leaders. I don't even touch on the more precarious problem of who will select the psychological experts.

6. *The Need to Re-emphasize Our Simple Psychological Viewpoint.*—Perhaps this was our ripest lesson, that we learned, after many mistakes, to recognize that there are only a few ears open for direct psychiatric advice. In the beginning we were too easily tempted to give explanations and interpretations, even when no questions were asked. Even in using our simplest semantics we have to be aware of the fact that people hear what they wish to hear, that journalists translate it into their sensational headlines, and that officials put it contemptuously somewhere in their files.

That is why we have to follow our own strategy of restraint. We give our honest and simple advice, even when it will not be translated into useful action. Next, we repeat our emphasis that there is a psychological approach and that psychological data are available. Official advisorship demands even more patience than individual therapy. We go through the same phases of resistance and transference, but we don't get the opportunity of working through them. However, modern psychological and educational technique is able to spread its convictions and to propagate its method, if it is aware of the resistance it has to conquer and the valuable bill of goods it has to sell.

With this my survey of experience is finished. Psychiatry and social psychology together are able to give useful advice in the management of crisis situations. The understanding of individual psychopathology and the knowledge of social pathology can be helpful to administrators and military authorities. Applied mental hygiene is no longer an illusion.

Sound psychological advice has been given as long as mankind has existed. The most brilliant example is that of King Solomon, who knew how to handle the mother's heart, by proposing to cut the disputed baby in 2 halves. In our epoch 2 opponents are fighting for the possession of Mother Earth. There are no longer any powerful and wise judges; so we attempt to train many little Solomons. Let us not forget that the final outcome will again be dependent on the spontaneous love of the mothers; without their help Solomon's judgment would have been of no value.

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A CASE OF ANOREXIA NERVOSA TREATED SUCCESSFULLY BY LEUCOTOMY

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"The soul is more stable with appropriate nourishment than when it lacks it." Hippocrates(1)

The term, "anorexia nervosa," used to label this patient may not be accurate. Several writers have objected to it. Dubois prefers "compulsion neurosis with cachexia"(8). Berkman proposes "anorexia with inanition"(9). Others have diagnosed patients suffering from similar symptoms as schizophrenics, obsessive neurotics, or hysterics. It is sometimes difficult to tell where neurosis ends and where psychosis begins. Although the patient discussed in this article had features of both, she did fulfill the criteria set by Cobb(2) for the diagnosis of anorexia nervosa: voluntary stopping of eating, loss of weight, and amenorrhea; and her case will be discussed under that heading.

CASE HISTORY

The patient, a 19-year-old girl, was admitted to the McLean Hospital for the third time complaining of fear of food, tension, and progressive loss of weight. These symptoms were of about 7 years' duration.

Family history revealed a closely knit group of 4: father, mother, patient, and younger sister. The father, described as hard-working, kindly, but hot-tempered when pushed, did not seem to be particularly affectionate. The patient's mother was described as an intelligent, excitable person, "the real boss of the family." Apparently she had been extremely close to the patient before the onset of the present illness. Then, however, they drifted apart. The patient's younger sister was described as attractive and somewhat irresponsible. Sometimes there was friendliness between the 2 girls, at other times, hostility.

Personal history revealed that the patient was born in New York after a normal labor with no complications during delivery. She was described as "precocious." Her mother reported with pride that the patient was toilet-trained at 6 months and that she talked at 8 months. There were no evident neurotic traits until the younger sister was born 2 years later, when the patient became highly nervous and excitable and had temper tantrums. These traits subsided after one year. Otherwise, she developed normally.

Her personality was described as good-natured but somewhat obsessive and apathetic. Though she was well liked because of her intelligence and sense of humor, the patient shied away from people. There was generally a lack of warmth in her relations with them. Determination of her moods was very difficult, her parents said, because of her "calm and collected" behavior. Preferring to be alone, the patient enjoyed intellectual pursuits. She spent a great deal of time reading in the local library. A perfectionist, she was always neat and industrious.

Medical history was not remarkable except for the severe malnutrition.

The present illness was closely associated with the onset of menstruation. The patient had always been aware of pregnant women and had felt somewhat disgusted and frightened by them. Following the rather ungentlemanly interest shown to her by a boy at her first dance, the patient became panic-stricken and rushed to her mother for reassurance. Soon after she showed great interest in her mother's diet and questioned her about the caloric values of food. Then, still self-conscious about her figure, the patient, too, began dieting. Within 2 months she lost 15 pounds. With that, her family took her to a doctor who prescribed a diet that included toast. Immediately there was conflict between the patient and her parents over her eating habits. From that time she felt progressively more antagonistic toward her mother. When she was 15, the patient was psychoanalysed for about a year. Her parents discontinued it because they felt both the patient's symptoms and her hostility toward her family were becoming more pronounced. As time went on, the patient felt tenser. She developed a fear of bread crumbs. Thinking that she might inhale them, she tried to protect her mouth and her nose by putting handkerchiefs or pieces of paper in front of them and by spitting out frequently. It became impossible for her to walk past restaurants. She could not be with people because she was afraid that they might have come in contact with food and might contaminate her. She lost more weight. As she isolated herself more and more from the outside world, she began staying in her own room at home. Her periods stopped, and she discussed the symptoms of her illness in great detail with her mother. Though she tried to sympathize with her daughter and to encourage her to eat, the mother was only occasionally successful. Often the daughter felt that her mother did not understand the nature of her illness. Once the patient received a series of electric shock treatments. There was temporary improvement. Soon, however, she returned to her old environment and to her weight-losing. With great difficulty she maintained herself through high school and graduated. She felt more and more uncomfortable with people. The patient was admitted to the McLean Hospital for the first time when she was 19. During her hospital stay she received ambulatory insulin

treatment and intensive psychotherapy. The insulin treatment lasted for about 2 months. The patient gained 20 pounds in weight and felt somewhat better. Upon discharge, however, she promptly lost all the weight she had gained and felt her phobias return with their previous intensity. Another admission to the McLean Hospital later in the year proved equally unsuccessful. During that time, the patient felt not only afraid of food, itself, but afraid of noxious food vapors that could contaminate her. She was progressively overwhelmed and made unhappy by these phobias. When she weighed between 80 and 85 pounds, she developed a mild upper respiratory infection. Because of her extreme malnutrition, she developed very severe complications. Her life was in danger. When she recovered, the patient was discharged from the hospital with the recommendation that a leucotomy should be performed as soon as possible. After a 2-month stay at home, she was admitted to the McLean Hospital for the third time complaining of the same symptoms.

Mental examination on admission revealed a shy, anxious person. Her speech was unintelligible at times because of facial tics and grimaces and because of interference from her hands in her nose and mouth. There were ritualistic behavior, facial assymetry, and dried saliva around her mouth. She talked quietly, however, discussing her symptoms in detail and unemotionally. She said she realized their absurdity, but she could do nothing about them. She seemed immersed in her illness. Otherwise, she showed good judgment and above normal intelligence. Memory and orientation were perfect. There was marked exhibitionist tendency.

Physical examination on admission showed evidence of marked malnutrition, avitaminosis, dehydration, red tongue, emaciation, cyanosis and hirsutism on both upper and lower extremities. Her weight was 75 pounds. Laboratory tests showed urine specific gravities of 10.31 to 10.33 but, otherwise, were negative. Hemoglobin was 11 gm.; but the red blood count, white blood count, and differential were normal. The NPN was 79 mg.%. The total protein was 5 gm. An electrocardiogram was essentially within normal limits. X-rays of the skull, chest, and lungs were clear; and the electroencephalographic record fell within normal limits.

During her stay on the ward, she spent most of her time in bed. When she was up, she wore men's clothes. In general, she seemed to be preoccupied by her body. At times she looked at herself in the mirror and assumed fixed positions. She reported imaginary scenes with herself as the heroine. In discussing her family, she spoke most often of her mother. She seemed to remember a rotten egg being forced into her mouth when she was very young.

Following a preliminary psychiatric study, which included daily interviews and psychological tests, the patient was operated on by Dr. William Sweet.

Description of the operation: A unilateral lower quadrant right frontal leucotomy was performed. The cerebral tissue was divided under direct vision but without suction in the coronal plane passing through the junction of the sphenoidal wings with the side of the skull.

This plane passed through the anterior-most tip of the anterior horn of the right lateral ventricle. The incision was carried medially until grey matter was seen at the apex of the gyri as well as at the sulci on the medial surface. The dorsal limit of the incision was at the roof of the lateral ventricle; the ventral limit was the pia on the orbital surface of the frontal lobe (*i.e.*, white and grey matter was divided here as well).

A strip of tantalum foil was placed in the plane of the incision, and its locus was confirmed by postoperative x-rays.

The patient emerged postoperatively with no complications. On the second day, she began taking fluids very easily. She refused other nourishment, however, as she had done before the operation. As soon as she was allowed out of bed, she started mixing with people. Within 4 days after the operation, her NPN returned to normal limits. Soon she began eating solid foods, and by the beginning of the third week, the patient ate normally for the first time in 7 years. Gaining weight rapidly, she attained 105 pounds a month after the operation. By 3 months, the patient's phobias had, for all intents and purposes, disappeared. By 7 months she was maintaining her weight at about 115 pounds and was in the upper tenth of her class at the university.

Discussion

From the psychiatric point of view it would be difficult to make dynamic formulations about this case. Certain features, however, may be pointed out as being of special interest: general oral preoccupation with especially the problem of "force" in feeding, exhibitionistic behavior, masculine tendencies, fear of pregnancy, and poor interpersonal relations with marked ambivalent feelings for mother and sister.

From the history it is to be noticed that the patient was trained in her bowel habits at an unusually early age. The story of the rotten egg suggests that she may have been forced to eat also. Certainly most of her gestures centered at her mouth. That orality and sexuality are closely related has been observed not only by psychiatrists but also by neurophysiologists after experiments with removal of the uncus region of the brain in monkeys(3).

Furthermore, the patient exhibited herself. Did she do this in an attempt to attract attention to her femininity or to deny it? Her masculine mannerisms and dress may have been ways of avoiding the feminine role. Certainly, her disease protected her in an

ingenious way: her inanition produced secondary amenorrhea. The absence of periods and the resulting inability to become pregnant negated womanhood.

Fear seemed to be the outstanding emotion in her case. It gave rise to considerable tension and anxiety, especially at the thought of food. The tension and the patient's peculiarities concerning food came between her and other people. She turned to herself for gratification.

The chief danger in cases of severe anorexia is death from starvation (2) or from secondary infection. The attention of the psychiatrist, therefore, is constantly shifted from the emotional problem responsible for the stopping of eating to the material difficulty resulting from it. The situation must be handled with the utmost gentleness. Forced feedings produce hostility, which can interfere with successful psychiatric treatment. With this patient many forms of treatment were attempted: psychoanalysis (incomplete), electric shock, insulin, and intensive psychotherapy. None of them helped her appreciably.

Because of those failures, because of the 7-year duration of the disease and because of the complications endangering the patient's life (10), the decision to perform a leucotomy was reached. In an attempt to avoid postoperative personality changes, the operation was as conservative as possible: a unilateral lower quadrant right frontal leucotomy was performed after a small triangular piece of bone had been removed. There was direct visualization of the brain throughout the operation. It was felt that, if no improvement in the patient was observed, the left side would be operated upon later.

Evaluation of the patient's improvement meets with many difficulties. In an attempt to avoid them, the following conditions will be referred to: presenting symptom and tension; personality (social behavior; intelligence quotient, planning, and judgment); physical condition (muscular activity and speech, weight); syndrome of irresponsibility, impulsivity, lack of drive, and apathy.

Soon after the operation, the patient began eating more than she had. She described herself: "My phobias do not bother me as much as they did" and "I am not as tense as I was about food." Three months after the operation she said that the phobias had disappeared "as if a great weight had been removed."

The patient's personality had certain character traits that did not seem to have been altered either by her illness or by the operation. Obsessive features, for example, said to have been present in her childhood, remained throughout her illness and are present today. Whatever she had undertaken to do, then and recently, she had done as best she could. She was and is a perfectionist. Her intellectual interests and her neatness have remained unaltered.

Her social behavior, on the other hand, has changed considerably. Soon after the operation, the patient showed a tendency to mix with people and to wear more becoming clothes. She attended occupational therapy, cooperated pleasantly with the nurses, and became friendly with the patients. Her relations with the family also improved slightly although the patient still has marked ambivalent feelings toward her mother and sister.

The patient was given the following psychological tests: "Wechsler Bellevue," "Rorschach," "Sentence Completion," "Draw a Person," "Memory for Designs," and "Bender Visual Motives." After the operation her IQ increased from 113 to 129. She seemed to be able to express herself with more freedom and to concentrate better on the tests. While she was in the hospital, the patient thought much about her future and planned for continuation of her college work. After discharge she enrolled at a university as a special student. At the present time, 9 months after the operation, she is doing excellent work. Her judgment, at all times excellent, was not improved by the leucotomy.

There were no physical complications: no seizures, no incontinence, and no headaches.

And there was an improvement in muscular activity and speech. The patient's facial expression changed dramatically. Her tense, drawn facies vanished, and a smile came to her face frequently. The grimaces, facial asymmetry, and sucking movements of the mouth, which at times had made her speech unintelligible, also vanished. The awkward walking was replaced by graceful movements.

Within 2 months the patient gained 35

pounds. Eating carbohydrates excessively, neglecting the fats and proteins, she is now maintaining her weight at a 40-pound gain. Experiments on animals have shown increased food intake following removal of the frontal lobes of the brain(12). In this case, as in others, better nutrition accompanied an improvement in mental symptoms(1, 11).

At no time was there any evidence of the impulsivity, apathy, and irresponsibility that have been described as complications following leucotomies. If anything, there was unusual drive that led to a period of mischievousness. This mischievousness disappeared, however, after 2 or 3 weeks, and the drive

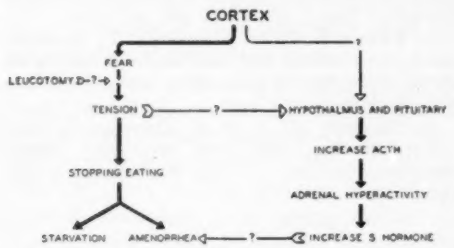

FIG. 1.

was canalized into more successful forms. The patient improved her interpersonal relationships and her grades in school.

Histopathologically, there was no abnormality in the specimen of cortex that was removed from the frontal lobe area.

Cases of anorexia nervosa must, at times, be differentiated from cases of panhypopituitarism(2). This patient presented no problem. There was evidence of hyperactivity of the adrenal cortex, although initially the 17-ketosteroid excretion was slightly lowered owing to starvation. The glucose tolerance was impaired and became more so after only 25mg. of ACTH given intramuscularly. The eosinophil count was low and showed a fall of 74% after ACTH and 55% after epinephrine. When the food intake increased, the excretion of 17-ketosteroids showed a fourfold rise. These findings are in accord with Altschule's theory that patients with some forms of mental illness like schizophrenia, manic-depressive psychosis, and certain neuroses, show a hyperactivity of the adrenal sugar-regulating hormone(4, 7, 13).

It is conceivable that the leucotomy by decreasing emotional tension may have indirectly inhibited the hyperactive adrenal cortex with a resulting increase in the eosinophil count and return to normal levels of the glucose tolerance test. What happens clinically and physiologically may be correlated as in Fig. 1.

It is assumed, therefore, that the leucotomy helped to bring about a decrease in the tension resulting from the emotion of fear and that it indirectly helped correct the physiological abnormalities as well as the rest of the clinical symptoms. Whether it was the patient's upbringing, environment, and attitudes to her problems, or whether it was other physiological factors that gave rise to the original emotion, fear of food, is a question still to be answered.

SUMMARY

An attempt has been made to present the successful treatment of one case of anorexia nervosa and to bring together some of the psychiatric, physiological, and surgical aspects of that case.

After 7 years' duration of the illness, the patient was in danger of death from starvation. She had been treated previously by electric shock, insulin, and psychoanalysis (incomplete).

A unilateral lower quadrant leucotomy was performed with direct visualization of the brain.

By 9 months after the operation the patient was maintaining her weight at a 40-pound gain. Tension had disappeared. Her interpersonal relations had improved markedly, and her IQ had risen 16 points. Ungraceful gestures and clothes improved. No physical complications or evidence of apathy, impulsivity, or irresponsibility were observed.

Physiologically there was evidence of hyperactivity of the adrenal sugar-regulating hormone before the operation. After the operation this physiological abnormality was corrected.

In spite of the fact that the leucotomy was successful in this case, it is believed that such an operation should be considered only after other forms of treatment have failed and should be as conservative as possible.

ADDITIONAL NOTE (One year after the operation)

At this time the patient is doing well. She has no phobias that interfere with her daily life. She continues her studies at the university.

Her eating, although not adequate at times, has not interfered with her daily activities. She maintains a weight of 108 pounds.

The author wishes to express his appreciation to Drs. S. Cobb, M. D. Altschule, and W. Sweet for their very helpful criticisms and comments.

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CONTROVERSIAL INDICATIONS FOR ELECTRIC CONVULSIVE THERAPY[1]

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When electric convulsive therapy (ECT) appeared on the psychiatric scene, the resistance against this new form of treatment was unusually violent. The criticism was not entirely unemotional. Statements made at that time condemning ECT would make interesting reading at present.

These facts are mentioned here since we believe that the hostile reception that ECT originally found has in turn induced the proponents of the new method to be overcautious and overcareful in their attempt to work out indications and contraindications.

Because the method was superior in the treatment of the major affective disorders, the workers actively engaged in ECT have been careful to stress this particular indication (2), and to regard treatment of the neurotic disorders as belonging exclusively to the domain of psychotherapy. Kalinowsky (9) and Sargant and Slater (11) stated that neurotics may be harmed by ECT and that particularly anxiety, the most frequent neurotic symptom, may be aggravated by it. In the neurotic group ECT is generally considered to be indicated in neurotic depressions only. Gayle and Campbell, however, have recently recommended ECT for relief of anxiety(5).

In general, the proponents of ECT appear to be on the defensive, fearful of more severe criticism than they have already received. In our opinion, this attitude has hampered a broadminded, all-embracing approach to the question of whether ECT may not be beneficial in instances other than the generally recognized major indications. It is the purpose of this presentation to describe some of the less frequent and less clear-cut indications, among them exceptions from the rule that neuroses should be exclusively approached by psychotherapy.

As far as neurotic depressions are concerned, it has been emphasized that ECT may be helpful in case the affective component in the disorder is of major importance. This is undoubtedly true for what has generally been described as neurotic depression, a rather ill-defined entity. We found ECT of great help in treating cases in which the clear-cut, dynamically understandable and approachable neurosis has been overlaid by a serious depressive affect. The removal of the depressive element by ECT is usually smooth and facilitates continuation of psychotherapy.

Next, we should like to mention a group of cases not usually covered by the diagnosis, "neurotic depression," that have already been studied in their response to ECT by Hauser and Peters(6). These authors have described a "clinical syndrome in which the symptomatic expression of the illness consists of a group of somatic complaints similar to those seen in anxiety psychoneuroses." Visceral autonomic features predominate. These cases, however, do not show true anxiety although they are usually misdiagnosed as anxiety states or anxiety hysteria. Their depressive character manifests itself by a phasic, anhedonic state, by the characteristic depressive features of inhibition of will power, inability to visualize the future or to plan for it, by complete absence of relief from unburdening interviews, and by changes in weight and menstrual disorders. They are completely resistive to any form of psychotherapy, including long-term psychoanalysis. As it appears to us, the basic affective disorder is overlaid and masked by more or less bizarre physical, hypochondriacal complaints; it is for this reason that Hauser and Peters have designated this group as conversion depressions. These cases are hardly ever considered by the psychiatrist as presenting a valid indication for ECT. In our experience, however, they do respond almost uniformly in a very satisfactory manner, and this response may, of course, be interpreted as a further indication of their disguised, but nevertheless true, depressive nature.

[1] Read in abstract before the 8th Annual Meeting of the Electro Shock Research Association, Atlantic City, N. J., May 10, 1952.

From the Department of Neurology, College of Physicians and Surgeons, Columbia University, and Neurological Institute, Presbyterian Hospital.

We have found a larger group of cases to be designated as pseudoneurotic depressive equivalents, showing a similarly satisfactory response to ECT. While in the conversion depressions of Hauser and Peters the outstanding manifest symptoms consist of somatic complaints, the pseudoneurotic depressions do not present such complaints. Anxiety, inferiority feelings, vague compulsive-obsessive features, or the neurasthenic syndrome may be the surface symptoms. The depressive core is virtually identical with the one described as characteristic of the conversion depressions. There is the anhedonic affective situation with inability to make decisions, to visualize the future, with inhibition of will power, with short hours of sleep, and loss of weight. The outward manifestations, however, the complaints, the presenting symptoms, give the impression of a common neurosis without physical manifestations. Most of the patients of this type had undergone psychoanalysis of long duration, or other forms of psychotherapy. Their response had been usually nil, a fact that had deterred neither the patients nor the analysts from continuing for years. When we discussed their analytical experiences with these patients, we were impressed by their inability to relate any tangible contents of their analytical interviews. The true depressive nature of this type of disorder can be detected by subtle features: for instance, one patient, when asked to speak about the influence of the analytical procedure on his condition, told us that he had been most impressed by the enormous effort it had cost him to talk. This was the typical Kraepelinian inhibition of will power, one of the cardinal symptoms of the depressive psychosis. The patient did not mean to refer to psychogenic inhibitions to talk about himself, but talking as such, talking about anything; talking, like any other activity, required more will power than he could master. It may be mentioned that these pseudoneurotic depressive equivalents may be particularly hard to recognize since their phasic nature is not as clearly evident as might be expected from a disorder that probably basically belongs in the manic-depressive group. The onset of the episodes is imperceptible and, while they terminate spontaneously, they usually continue for a fair number of years before reaching a spontaneous termination. Decades may elapse before the appearance of a second episode. The termination of these episodes by ECT is as immediate and complete as in a clear-cut depressive psychosis.

The 2 groups just sketched, the conversion depressions and the pseudoneurotic depressive equivalents, to be strictly logical, do not belong in the scope of this presentation since they fall under the already fully accepted indications, being affective disorders. They have been mentioned here briefly since their basic affective nature is usually not recognized and since therefore the benefit of ECT is being withheld from these patients.

At this point, we desire to make it clear that we do not advocate ECT on general principles as treatment for neurotic disorders. This would be sheer folly. Nevertheless, in exclusively neurotic situations, ECT may frequently be of decisive benefit. While it has to be integrated into the over-all total push of psychiatric approach, it should not be considered to be of merely ancillary importance to psychotherapy since its administration in these situations often marks the turning point from therapeutic failure to therapeutic success.

We found this to be true in cases of anorexia nervosa, in whom long-term and energetic psychotherapy, which had succeeded in unraveling the underlying dynamics, had not succeeded in breaking up the vicious behavior pattern. A situation seems to prevail in these cases that also may be encountered in other neurotic disorders. While the dynamic approach is proceeding apparently logically and at a normal speed, there is no loosening up of the symptomatology, which seems to have acquired the ability to survive as a "facade of symptoms" (4) even though the originally responsible dynamics have been resolved. Here, ECT seems to serve to break up the conditioned pattern and, once the symptom has been removed, the situation can be stabilized by further continuation of psychotherapy.

The most interesting group consisted of individuals of either sex, of schizoid personality make-up, who presented serious neurotic complications, sometimes of many years' standing. ECT in this group was undertaken

with great hesitancy but the results proved to be unexpectedly rewarding. We prefer to classify these patients as schizoids with a superimposed neurosis, although many psychiatrists would diagnose them as borderline schizophrenics, or as belonging in the group of pseudoneurotic schizophrenics described by Hoch and Polatin(8). Our patients do differ in essential aspects from the pseudoneurotic schizophrenics. They have in common with the cases of Hoch and Polatin a somewhat autistic and dereistic life approach. This, however, is not as pronounced in our group as it is in the pseudoneurotic schizophrenics. Affective rigidity, if present at all, is also mild, no more than could be reasonably expected in a schizoid. They fail to show the diffuseness of ambivalance (polyvalence). If they have inappropriate emotional reactions, these are only localized and complex-bound. The same applies to the anxiety, which even if it later assumes the degree of pananxiety can nevertheless always be traced and reduced to an originally complex-bound anxiety. Anhedonic states and confusion between foreground and background are absent in our cases. Also, in contrast to the pseudoneurotic schizophrenics, our patients experience no difficulties in describing complaints and dynamic history in detail. Their sexuality is less chaotic than that seen in the pseudoneurotic schizophrenics. It is rather plainly immature. All in all, it may be stated that, whereas the cases of Hoch and Polatin are psychotics, who may appear as neurotics, our cases are neurotics of schizoid constitution, who may develop reactions that quantitatively assume psychotic proportions, but qualitatively remain of basically neurotic structure.

While adolescents and young adults form the majority of this group, middle-aged patients with the same condition were occasionally seen and successfully treated. All cases had undergone unsuccessful psychotherapy or psychoanalysis for periods ranging from 8 months to several years before they came to us. Lasting results after ECT in some of these cases were observed, even without follow-up psychotherapy. Three cases may be reported here for illustration.

1. Miss R. P., age 25, leptosomic habitus, was seen for the first time on September 5, 1950, giving a "life-long" history of very frequent attacks of "terrific diarrhea and vomiting" whenever slightly tense, particularly when expecting to go out on a date, or when looking for a job. Most members of her family were reported to be "nervous." He father died when the patient was 1½; the mother remarried when the patient was 13. Relation to stepfather was allegedly good. She remembers attacks of diarrhea and vomiting in early childhood when visiting her grandmother; later, at school or under any other occasion that induced tension. Never received information about sex from her mother, to whom she was and is very close; up to the age of 11 believed in the stork. Sex was considered to be dirty. Menarche at 17. At the same age started to go out with older men, around 30. Vomiting and diarrhea prior to each date; unable to eat at all while going out. Revealed very high degree of self-deprecatory attitude: "dumb, dumb, no ambition"; this in definite contradiction to facts since she was holding a responsible office position. Prior to seeing us had had intense psychiatric and psychoanalytic treatment, without results. The impression was that of an immature, introverted, schizoid individual with a rigidly fixed, deep-seated neurosis of many years standing.

The patient returned on May 2, 1951. She had recently lost twelve pounds in 9 days and stated that she was "cracking up—there comes the crack-up." She was engaged and in a state of extreme panic concerning her impending marriage, particularly the wedding. She threatened suicide and at the same time expressed her ardent love for her fiancé, stating that he was the only man she would consider marrying but that she simply could not go through the necessary formalities and ceremonies. There was no true depressive affect but excessive panic. Before returning to us the patient had returned to the 2 psychiatrists who had previously treated her. She had been advised to postpone marriage and embark again on a course of psychotherapy. Reluctantly, this patient was started on ECT with the idea that, as in anorexia cases, the treatment might break up the vicious behavior pattern of diarrhea and vomiting and that its blunting effect might favorably influence the panic. Treatment was started on May 9, 1951, and the last, and 9th, treatment was administered on May 28, 1951. All treatments, on account of the excessive fear, were given under Pentothal anesthesia. In view of the fact that the patient had already received an ample dose of psychotherapy and psychoanalysis, no psychotherapy was given in conjunction with the treatment.

At the termination of the treatment period the panic had disappeared entirely while the blunting and memory defects were only mild. About 2 weeks after the last treatment she was married with the usual ceremonies and without any difficulties, anxiety, or panic. Her marriage is a happy one although she has not made a satisfactory sexual adjustment, being unable to achieve an orgasm. The symptom that had been the outstanding one through her life, nausea and vomiting, has not reappeared. Only occasionally before attending social affairs she complains of "butterflies in her stomach." While there is no doubt that the basic immature schizoid person-

ality make-up has remained unchanged and while the patient still has to be classified as a neurotic, the application of ECT alone, not in conjunction with psychotherapy, enabled her to fulfil her outstanding desire, to get married, and at the same time to a considerable degree broke up the disabling symptomatology, which had not yielded to intense psychiatric approach.

2. Master J. H., 14, athletic habitus. Family history negative. While outwardly well adjusted, always jumpy, occasionally sleepless, and of schizothymic or schizoid premorbid personality make-up. For about one year suffering from uncontrollable involuntary motor phenomena, consisting of shaking his head, hitting his head with his hands, and tic-like motor phenomena in the upper and lower extremities. Patient had undergone intense psychotherapy for 8 months in his home town, without amelioration of his symptoms. Investigation had revealed that the movements were performed in an attempt to shy away sexual fantasies that he considered to be sinful. There was an excessive sense of guilt concerning masturbation. Shortly before the boy was referred for ECT he had refused to go to bed, apparently being afraid of falling a victim to sexual fantasies or masturbation in bed. When he eventually could be induced to lie down, his parents were kept awake by the noise of his pounding his head.

The boy was started on ECT on March 4, 1949, and the 15th, and last, treatment was given on April 6, 1949. There was a complete cessation of symptomatology. No psychotherapy was administered in conjunction with the shock therapy. The patient refused to return to the psychiatrist in his home town and could not return to the writer for follow-up psychotherapy. However, he had a few interviews with a nun, who was his favorite teacher in his parochial high school. There has been no recurrence and the patient has continued to remain entirely well and to develop normally during the 3 years since the application of ECT. He was recently elected president of the student council.

This case is diagnostically difficult to classify. While the motivating dynamics were clearly discernible, the degree of the symptomatology, which resembled a choreic syndrome, exceeded what could be expected in a neurosis. Also, for a purely neurotic condition, the complete failure of 8 months of intensive psychotherapy would be somewhat unusual. On the basis of the schizoid make-up, neurotic mechanisms precipitated a borderline schizophrenic syndrome. The symptomatology was completely and lastingly eliminated by ECT, without further psychotherapy.

3. Master A. K., 16, dysplastic habitus. Overprotective mother; submissive, aloof father. Past history of coeliac disease, frequent episodes of constipation and vomiting during childhood to the age of 12. When seen was still under the care of a gastroenterologist, who gave regular colonic irrigations. Since the age of 12, frantic fear of nausea but without its occurrence. Attending school very irregularly on account of fear of becoming nauseated in school. Episode of truancy of an entire term owing to this fear. Left his apartment each morning, spending the day on the roof of the building, intercepting and answering letters from school authorities. Exceedingly attached to his mother. Panicky when mother made an attempt to go out or leave him alone. For the last 2 years had prevented mother from leaving him even for minutes, going into wild temper tantrums whenever mother tried to leave him. For the past 2 years excused from school. Uninterrputed psychiatric treatment since onset; for the last 2½ years psychoanalysis. Introverted, severely schizoid personality. Very tender feelings for plants and animals; harsh cruelty toward his indulgent parents, hitting his mother. No friends. Sophisticated, highly intelligent, and skeptical. Undernourished, owing to insufficient food intake on account of fear of nausea.

Notwithstanding the intense past psychotherapeutic and psychoanalytic procedures the writer started this patient on psychotherapy. After 2 months the diminishing food intake approached anorexia nervosa, and wild temper tantrums and aggressive behavior directed against the mother induced us to administer ECT. A total of 18 treatments was given. Psychotherapy was resumed after termination of ECT and regularly continued for the following 7 months. However, immediately after termination of ECT the patient was already able to attend school and, notwithstanding the years of absence from school, graduated from high school after attending the last term. His food intake increased. Psychotherapy, which had been completely unsuccessful prior to the application of ECT, was facilitated. Gradually, patient allowed his mother to leave him and assumed a fairly normal pattern of life.

When seen last, in September 1951, he still spoke of fear of nausea. Naturally, he was still a severe neurotic and of course had all the earmarks of his schizoid personality. However, he functioned fairly normally, holding an office position.

Different as they are in many aspects, these 3 briefly abstracted cases and others, not reported, have a number of essential features in common: the basic schizoid personality make-up; the extremely disabling symptomatology, sometimes of very long standing, qualitatively neurotic, quantitatively often within the psychotic range, a symptomatology dynamically understandable but unimproved by psychoanalysis or other forms of dynamic psychotherapy; and, most important of all, termination of this disabling syndrome and assumption of at least outwardly normal conduct after ECT. In addition to the lasting break-up of the conditioned, disabling neurotic behavior patterns, these patients experienced marked lessening, or complete disappearance, of anxiety and panic. This could not be ascribed to blunting since anxiety did not reappear at the end of the blunted period.

We saw complete therapeutic failures in all patients treated who belonged to the compul-

sive-obsessive group. The blunting effect of shock treatment results in an amelioration of the compulsive-obsessive symptomatology; this effect disappears simultaneously with the blunting and all patients return to their former status.

An ancillary, but very helpful, rôle can be played by ECT in the treatment of narcotic addiction. This has been pointed out previously(10) but has never been undertaken on a larger scale in this country. Recently, favorable results have been reported from Japan (Watanabe). Let there be no misunderstanding about it; ECT is not being recommended in any way as treatment for the psychopathology of drug addiction. It is to be highly recommended, however, as a tool for the management of the withdrawal period. The so-called "annihilating" form of treatment should be used and we have found 2 to 3 treatments administered daily for a period up to 7 days to be of the greatest help in overcoming the host of withdrawal symptoms. Restlessness, vomiting, diarrhea, weight loss, and insomnia can be noted even with this form of treatment, but are much milder than with the usual modes of management. Most important, the patient hardly minds them; the commonly present excessive degree of anxiety and agitation is missing and the somatic symptoms, even when present, are not fully appreciated; blunting, confusion, and almost total oblivion take the place of agitation and despair.

The results described in this paper were obtained with the standard Cerletti-Bini technique. While in some cases we have the impression that shock was of value because it facilitated psychotherapy, which had apparently been blocked by a rigidly conditioned behavior pattern, in other cases improvement appeared to be attributable almost wholly to shock treatment, with psychotherapy playing only a minor additional rôle, or none at all. We feel that these results are important, especially in view of recent claims advocating other methods of cerebral electrotherapy, such as nonconvulsive electric stimulation. Some authors(1, 7) have practically postulated a specificity of the effect of various types of electric current and application of the electrodes for various diagnostic categories. Our results were achieved by the same standard method in widely different diagnostic groups. We therefore hesitate to assign specific modes of application of electrotherapy to specific disorders.

Summary

Aside from the recognized indications, ECT was found to be of decisive help in conversion depressions, a syndrome in which somatic, chiefly visceral autonomic features mask the phasic depressive core. Similarly favorable responses were achieved in pseudoneurotic depressive equivalents, conditions that possess the same phasic depressive core as the conversion depressions, whereas the outward symptoms may mimic anxiety states, compulsive-obsessive or neurasthenic syndromes. In anorexia nervosa, ECT breaks up the conditioned behavior pattern and facilitates psychotherapy. Schizoids with superimposed disabling symptomatology of qualitatively neurotic nature, but quantitatively psychotic degree, showed the most gratifying responses inasmuch as the disabling behavior patterns were broken up by ECT. Improvement of anxiety also was observed. Cases of true compulsive-obsessive neurosis never responded. In narcotic addiction, ECT is a highly valuable tool as far as management of the withdrawal period is concerned. The fact that results were obtained in vastly different conditions by the same standard method creates hesitation as to recent tendencies to assign different modes of electro-therapy to different diagnostic categories.

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PSYCHOLOGICAL STUDIES ON PATIENTS UNDERGOING NON-CONVULSIVE ELECTRIC-STIMULATION TREATMENT [1]

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INTRODUCTION

This exploratory study was undertaken to supplement clinical observations on patients undergoing nonconvulsive electric stimulation therapy (EST). As described by Hirschfeld (9 and 10) this type of treatment employs a brief-stimulus square-wave current identical to the type used by Liberson(17) in his brief-stimulus electroconvulsive therapy; but for EST the current is kept at a nonconvulsive level.[2] As consciousness is not lost during passage of current, pain is experienced. Therefore, patients receive an intravenous injection of 5% Pentothal Sodium [3] prior to treatment.

Hirschfeld has reported "improvement in mental capacity" and lessening of clinical symptomatology in patients with specific psychiatric syndromes, particularly in "certain anxiety states, paranoid schizophrenics [4] and psychosomatic conditions" (9, p. 5). Confusion and memory loss were clinically not observable, even immediately following EST.

The effects of various forms of electrotherapy have been the subject of much controversy. At least temporary adverse changes in memory and other cognitive functions suggestive of organic brain damage following classical electroconvulsive shock with continuous alternating current (ECT) have been widely observed and also described in various psychological studies(2, 11-14, 18, 25, 29, 30, 34-36).

Within the last few years, attempts have been made to evolve different types of electrotherapy techniques with which such damage could be minimized. Liberson(17) contends that his brief stimulus electroconvulsive therapy (BST) avoids such damaging effects and that usual tests of memory or intellectual functions given 4 or 5 days after a series fail to detect any impairment(17, p. 35). His claim is further supported by Scherer's systematic psychological experiments on patients undergoing a series of BST(27). Scherer's postshock battery, however, was administered "from two to six weeks after termination of BST"(26, p. 432). According to most observers one can expect a considerable amount of recovery of cognitive functions within such a time even with classical ECT.[5] Scherer's observations, therefore, do not include the period where impairment can be greatest, *i.e.*, shortly following treatment.

Avoidance or reduction of undesirable side effects has also been claimed for electrotherapy with Reiter's unidirectional current(1, 4, 34). Summerskill *et al.*(31) report a psychological study indicating that post-EST confusional effects from the Reiter Electrostimulator are negligible. They administered their posttreatment battery within 30 minutes after application of current, but they studied only the effect of one single treatment, the first of a series. Thus, their investigation does not deal with the well-known cumulative effects of several treatments.[6]

Even more controversial are the effects of conventional ECT on personality functions. Numerous psychological studies differ widely in their positive and negative appraisal(12, 20, 23, 25, 26, 29). Some psychological investigations of emotional adjustment changes effected by the newer techniques are on the way or have come out very recently. In the above-quoted study, Scherer reports "scattered test evidence [7] that brief stimulus ther-

[1] From the Veterans Administration Hospital, Lyons, N. J.

Published with the permission of the chief medical director, department of medicine and surgery, Veterans Administration, Washington 25, D. C., who assumes no responsibility for the opinions expressed or conclusions drawn by the authors.

[2] Average spike duration of 0.3 milliseconds, peak of 80 milliamperes and frequency of 120. Average current meter readings are about 2 milliamperes. Equipment is manufactured by Offner, Chicago.

[3] Sodium ethyl thiobarbiturate.

[4] Without marked disorganization of personality.

[5] See in particular Stone's (30) and Janis' (13) psychological studies. In the latter, Janis describes a new and refined technique with which he was able to measure residual and more subtle memory defects even following the "recovery period" after ECT.

[6] See references 11, p. 38, and 35, p. 102.

[7] From group Rorschachs.

apy shows some positive orientation changes," (27, p. 434).

The present study has a purpose similar to the previous and numerous psychological investigations of various forms of electrotherapy. We are attempting to describe some effects of nonconvulsive electric stimulation therapy as reflected in psychological test performances, including measures of intellectual and of general personality functions.

The above studies pointed out the importance of testing shortly following treatment as well as of studying the cumulative effect of a series. This study tries to take these factors into account. There were necessary limitations. The study was set in a busy hospital ward where experimental considerations had to be secondary to treatment necessities. Immediate posttreatment testing was not always possible and a control group of hospital patients was not available. Investigation also had to be limited to standardized and quantifiable measurements and thus could only explore gross aspects of changes.

SUBJECTS

The subjects in the experimental group were hospitalized white, male veterans who had been designated by the medical staff for EST. Of this group, 19 patients who had not previously received any form of insulin or electric therapy were chosen as subjects for the study. Their ages ranged from 21 to 46 years, with a mean of 29 years. They all presented clinically no marked personality disorganization and were considered as severe neurotic or mild, borderline schizophrenics. Their psychiatric diagnoses are indicated in Table 1.

The control group included 15 subjects taken from applicants for treatment at a veterans mental hygiene clinic. Those applicants who were most comparable to the experimental group, severe neurotics and borderline schizophrenics, were chosen (for diagnoses see Table 1). All subjects were white, male veterans. Their ages ranged from 25 to 55 years, with a mean of 33 years. The experimental and control group were matched for intelligence with the Revised Beta Examination.

SELECTION OF TESTS

A. *Tests of Intellectual Functioning.*—Investigations of changes of intellectual functioning with therapy have commonly used a test of general intelligence. In this study the Revised Beta Examination(15) served this purpose. This test was used because it contains many measures of functions likely to be affected by organic brain changes, such as visual-perceptive discrimination, nonverbal concept formation, visual-motor coordination and speed, as well as other tasks involving "new learning." It also is simple to administer and score. For an over-all evaluation of memory functions the Wechsler Memory Scale, Form I(32) was used. Three other short verbal tests investigating functions not specifically dealt with in the Beta and the Wechsler Memory Scale, and which might be altered by treatment, were included: word naming(18) for spontaneity and fluidity of associations, similarities of Wechsler-Bellevue, Form II(33) for verbal concept formation, and vocabulary of Wechsler-Bellevue, Form II, for a measure of verbal facility.

TABLE 1

PSYCHIATRIC CLASSIFICATION OF EXPERIMENTAL AND CONTROL GROUP

Psychiatric diagnosis	Experimental group	Control group
Anxiety reaction, severe	8	5
Anxiety reaction with schizoid features	0	3
Obsessive compulsive reaction	0	2
Conversion hysteria	0	1
Asthenic reaction	0	1
Phobic reaction	1	0
Neurosis, prepsychotic state	0	1
Neurosis, unclassified	0	1
Schizophrenic reaction, paranoid.	3	1
Schizophrenic reaction, unclassified	6	0
Schizophrenic reaction, simple	1	0
TOTAL	19	15

Rather than use alternate forms, the identical battery was given in retesting. Practice effect was controlled by means of the control group.

B. *Measures of Personality Functions.*[8]—The individual form of the Minnesota Multi-

[8] For a more detailed explanation of this part of the study, see Perkins(21).

phasic Personality Inventory (MMPI)(8) was chosen because it evaluates a wide range of personality functions. This test has been found of value in assessing personality changes in therapy by several authors (5-7, 20, 24, 28) despite its limitations as a diagnostic and prognostic tool. The individual form of the Rorschach was selected to explore more basic and less conscious personality characteristics. Twenty signs and patterns, modified slightly from the studies of Muench (19) and Carr(3), were selected for use in this study. The criteria of "normality" established by these authors were applied and used for comparison with our pre- and post-protocols.

PROCEDURES

A. *Intellectual Functioning.*—The 19 subjects of the experimental group were administered, before the first EST, a test battery consisting of the Beta; Wechsler Memory, Form I; Wechsler-Bellevue, Form II, similarities; Wechsler-Bellevue, Form II, vocabulary; and word naming tests. After the 10th EST (within 0 to 6 days, a mean of 3 days) the tests were readministered to the 19 subjects. The interval between initial and second testing ranged from 17 to 78 days, a mean of 30. The 10th EST was arbitrarily chosen as the point of retesting since the total number of ESTs varied widely. The interval between the first and tenth treatment ranged from 13 to 22 days, a mean of 16 days.

The subjects of the control group were administered the Beta and the Wechsler Memory Scale, Form I, only, when they applied for treatment at the VA Mental Hygiene Clinic. They were retested with the same 2 tests a mean of 17 days (range 13 to 28 days) later, during which time they received no treatment.

Of the 19 subjects in the experimental group, 9 were tested for a third time with all the tests after EST had been completed and the patients were considered sufficiently improved that they were scheduled to leave the hospital on trial visit or to be discharged.[9] Their total number of treatments ranged from 14 to 41. No controls were available for this part of the study.

B. *Personality Functions.*—This portion of the study includes 10 patients of the 19 in the experimental group. With 2 exceptions, they were identical with those 9 "improved" subjects previously discussed. The 2 additional patients were also considered sufficiently improved for trial visit. All 10 patients received the Rorschach and the MMPI before treatment. If a patient had been given a Rorschach with his diagnostic battery upon admission to the hospital, it was not repeated, although a month or more might have elapsed. The MMPI was administered within 9 days before treatment. All tests were repeated within a week after final treatment, except for 2 patients, one of whom was tested 9 days and the other 16 days after termination.

TABLE 2

INITIAL MEAN TEST SCORES OF EXPERIMENTAL AND CONTROL GROUP

Test	Experimental group	Control group	Difference (experimental minus control group)
Revised Beta (IQ Points)	101.3	104.0	2.7*
Wechsler Memory Scale I (MQ Points)	99.5	103.3	3.8*

* Statistically not significant (p greater than .40)

RESULTS AND DISCUSSION

The experimental and control groups were found to be comparable on the initial scores of the Revised Beta as well as of the Wechsler Memory Scale, Form I (see Table 2).

A.[10] INTELLECTUAL FUNCTIONING

The subjects of the experimental group achieved a mean IQ of 101.3 on the first administration of the Revised Beta. Following the 10th EST treatment, a mean IQ of 104.6 was achieved, yielding a mean gain of 3.3 points. This performance was compared

[9] When this study was completed the other 10 of the original 19 patients were still receiving EST or other types of treatment.

[10] The paragraph notation is identical with that under Procedure and indicates the results of the 3 individual portions of the study.

with that of the control group on test-retest over a relatively similar time interval during which treatment was not received. The initial mean IQ of the control group was 104.0. Retesting of the control group yielded a mean IQ score of 107.5 and a mean gain of 3.5 points. The difference between the mean gains of the 2 groups was found to be .22 points in favor of the control group; but a "*t*" test shows that this difference is statistically not significant (*p* greater than .80).

The subjects of the experimental group achieved a mean Wechsler Memory Quotient of 99.5 on the first administration of the Wechsler Memory Scale I. After the 10th EST treatment the group achieved a mean MQ of 107.9, yielding a difference between the means of 8.4 points. This performance was compared with that of the control group. The initial mean MQ of the control group was 103.3. Retesting of the control group yielded a mean MQ score of 110.8 and a mean gain of 7.5. The difference between the mean gains of the 2 groups was found to be .89 points, in favor of the experimental group; but a "*t*" test indicates this difference to be not statistically significant (*p* greater than .70).

The group of nine patients who were tested a third time at the conclusion of treatment continued to make gains on the Beta and Wechsler Memory. The mean gain of the group on the Beta between the second (after 10 ESTs) and third (conclusion of treatment) testing was 5.22 IQ points and between the first and third testings, 6.56 IQ points. The mean gain of the group on the Wechsler Memory between the second and third testings was 7.00 MQ points, and between the first and third testings 15.67 MQ points. It would seem that additional treatment did not prevent the group from making further gains on the test. Since the sample was small and there were no controls for comparison, the data were not treated statistically. The individual test scores of the experimental group on the Revised Beta Examination and the Wechsler Memory Scale for the first, second, and third testing appear in Table 3.

Of the 3 additional tests given to the experimental group only, the similarities and vocabulary tests showed mean gains in weighted scores of less than one point in both the second and third testings over the first testing. The word naming test showed a mean gain of 4 words between the first and second testings. The group of 9 patients

TABLE 3

REVISED BETA AND WECHSLER MEMORY FORM I SCORES FOR THE 19 PATIENTS OF THE EXPERIMENTAL GROUP IN SUCCESSIVE TESTING

Patient	Beta IQ			Wechsler Memory Scale MQ			Total ESTs received
	1st *	2nd †	3rd ‡	1st *	2nd †	3rd ‡	
1.....	102	101	102	114	105	108	22
2.....	114	101	115	90	105	103	17
3.....	106	105	110	97	100	108	23
4.....	103	110	116	96	110	126	14
5.....	75	79	86	65	73	79	18
6.....	97	101	101	92	105	114	27
7.....	85	91	98	86	93	94	33
8.....	114	116	117	90	100	108	41
9.....	89	93	99	72	89	103	14
10.....	104	106		124	124		
11.....	109	108		101	108		
12.....	110	114		99	100		
13.....	110	118		126	140		
14.....	100	109		100	110		
15.....	116	120		124	124		
16.....	110	120		108	135		
17.....	109	109		105	100		
18.....	94	104		122	137		
19.....	78	83		80	93		

* 1st testing prior to treatment.
† 2nd testing after the 10th EST.
‡ 3rd testing after termination of EST.

who concluded treatment showed a mean gain of 10 words between the first and third testing. The significance of these findings cannot be determined because no controls were available.

B. PERSONALITY FUNCTIONS

The pre- and posttreatment profiles of the MMPI were compared and the results are depicted in Fig. 1. For the group of subjects,

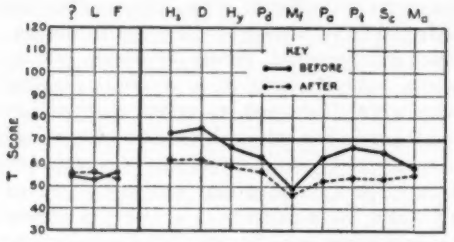

FIG. 1.—Mean T-scores of the patients before and after electro-stimulation treatment.

the .01 level. The schizophrenia scale shows a decrease significant at the .05 level (see Table 4). Although the paranoia scale shows a marked drop, it was not found to be significant. The significant differences indicate that the patients' attitudes have undergone considerable change, but control studies are still necessary.

An analysis of those items showing a change in the direction away from deviant and abnormal trends was also undertaken. The results were similar to the profile comparison and were interpreted to indicate that the patients, as a group, experienced a reduction of somatic complaints, a lessening of fatigue, an increase in feelings of self-confidence, a decrease in worry, greater emotional control, an increased ability to get along with people, as well as improvement in ability to concentrate. These findings of the MMPI studies are in agreement with clinically observed behavioral manifestations and

TABLE 4

THE SIGNIFICANCE OF THE DIFFERENCES OF THE MEAN T-SCORES FOR THE VARIOUS SCALES OF THE MMPI BEFORE AND AFTER ELECTRO-STIMULATION TREATMENT

Scale	Pretest Mean	Pretest S.D.	Posttest Mean	Posttest S.D.	Differences between means	Critical ratio of differences
?	56.1	9.30	56.3	11.88	.2	.08
L	54.5	6.32	55.8	6.27	1.3	.66
F	57.9	11.33	55.7	9.08	—.2	.58
Hs, Hypochondriasis	73.5	12.30	60.6	12.70	—12.9	3.54 *
D, Depression	74.7	14.28	60.8	8.73	—13.9	3.87 *
Hy, Hysteria	68.1	11.16	59.3	9.39	—8.8	3.33 *
Pd, Psychopathic deviate	62.9	14.48	58.4	12.50	—4.5	1.96
Mf, Masculinity-femininity	49.9	10.96	47.7	8.26	—2.2	1.05
Pa, Paranoia	62.7	19.57	51.1	11.09	—11.6	1.78
Pt, Psychasthenia	67.1	15.93	52.6	8.14	—14.5	3.97 *
Sc, Schizophrenia	64.9	19.62	52.5	9.30	—12.4	2.43 †
Ma, Hypomania	57.6	11.66	56.3	13.05	—1.3	.68

* p less than .01
† p less than .05

a decrease is noted in the mean T-scores of those categories primarily concerned with clinical symptoms, thus indicating a general reduction of such symptoms. A slight increase is shown in the validating "?" and L scales, which do not measure complaints. The majority of individual profiles also show a drop in score. When the "t" test for significance was applied, 4 of the scales, hypochondriasis, depression, hysteria, and psychasthenia, showed significant reductions at

self-evaluations of the patients in psychiatric interviews.[11]

Pre- and posttreatment Rorschach records were analyzed quantitatively on the basis of the previously selected 20 signs and patterns

[11] To supplement the clinical observations of improvement, a brief rating scale in essence similar to that used by Pacella *et al.* (20) was utilized. Conservatively interpreted on the basis of ratings derived from ward personnel, the subjects as a group may be said to have shown a "moderate degree of improvement."

of "normal" adjustment (see above). For the total factors there was a very small positive change in the direction of normality but this change did not approach statistical significance. If one inspects the tendencies of the changes within the 20 Rorschach factors (Table 5), one finds that on the basis of the

TABLE 5

PATIENTS SHOWING CHANGES IN RORSCHACH SIGNS OF ADJUSTMENT FOLLOWING ELECTRO-STIMULATION TREATMENT

Adjustment factor	Improvement	No change	Decrement	Improvement minus decrement
W%	5	3	2	3
M	3	4	3	0
M:FM+m	4	3	3	1
M+FC:(CF+C)	7	1	2	5
(k+kF+Fk)wt	2	8	0	2
K+KF	1	9	0	1
F%	6	0	4	2
FC	5	4	1	4
FC:CF+C	8	1	1	7
C	1	9	0	1
H—Hd	4	3	3	1
H+A:(Hd+Ad)	7	0	3	4
A%	1	6	3	—2
At+Sex	2	6	2	0
R	4	2	4	0
R+	3	4	3	0
P	3	3	4	—1
(VIII—X)%	4	4	2	2
Do	1	8	1	0
Rejection	4	5	1	3

improvement-minus-decrement column there are 4 signs showing indications of improvement. These are: FC:CF+C, M+FC:CF+C, FC, and H+A:(Hd+Ad). They suggest that the important trend in Rorschach score changes lies in the direction of increased emotional control and better adjustment to the environment.

Examining the individual records according to the Rorschach criteria of adjustment, we find that only 2 patients demonstrate any outstanding evidence of positive adjustment change and 2 others a slight degree of such change. The remaining 6 show negligible improvement and in some instances even decrement.

While clinical observation and MMPI show greater positive changes for the group, the Rorschach gains were slight. It is suggested that this might be due to the limitations of the quantitative method as well as the possibility that the Rorschach may be revealing aspects of the personality that are less easily subject to change. Also, the Rorschach is less likely to be influenced by a person's need to present a certain appearance.

SUMMARY AND CONCLUSION

It was attempted to study some effects of nonconvulsive electric-stimulation as they are reflected in psychological test performances. The experimental group consisted of 19 white, male patients of a veterans hospital who were diagnosed as severe neurotic or mild, borderline schizophrenics, and who had not received insulin or electric therapy before. The control group was composed of 15 white, male patients of a veterans mental hygiene clinic carrying similar diagnoses and comparable for initial test scores.

Tests of intellectual functioning (Revised Beta Examination, Wechsler Memory Scale, Form I, and some other tests of cognitive functions) were administered to the whole experimental group before EST and from 0 to 6 days after the 10th treatment. The control group was tested and retested with the Revised Beta and the Wechsler Memory Scale, Form I, at comparable time intervals. All tests of the experimental group showed a gain in mean scores upon retest after the 10th treatment but this increase was not significantly different from the increase obtained in the control group. The conclusion seems to be justified that no impairment or gain in cognitive functions were discernible as far as these functions are measurable by the tests used.

In order to assess the influence of a larger number of ESTs, 9 patients of the experimental group were tested with the same tests for a third time after successful completion of the treatment series, which varied from 14 to 41 ESTs. The group continued to make gains on the tests. As there are no controls available for this phase of the study, one can only infer that learning ability does not seem to be adversely affected by such a number of ESTs.

Ten patients of the experimental group were tested with the Minnesota Multiphasic Personality Inventory (MMPI) and the

Rorschach before and after completion of treatment. Significant differences were found between the pre- and posttesting for the categories hypochondriasis, depression, hysteria, and psychasthenia. An item analysis showed changes in the direction away from abnormal trends, indicating that the patients as a group felt reduction in somatic complaints, increase in energy and emotional control, as well as improvement in the ability to concentrate. Quantitative analysis of the Rorschach record showed no significant indications of change except for minor alterations pointing up a trend toward increase of emotional control and adjustment to environment. Statistical results must be interpreted in the light of the fact that there is no control group for the MMPI and Rorschach and that the mean differences might be the result of sampling error.

Further and carefully controlled studies are needed. Also needed are additional, more refined, and qualitatively oriented psychological investigations that may reveal more subtle emotional and intellectual changes that escape our notice, when we use standard, quantitative testing methods.

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AN EDUCATIONAL PROGRAM FOR DEVELOPMENT OF THE "NORMAL" PERSONALITY[1]

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In 1938 because of my conviction that we were sadly failing in our preventive efforts in the field of mental health, I started experimenting in teaching positive mental hygiene principles to normal boys and girls in our public schools.

Mental illness and neurotic behavior are the results of so many different causes, I do not believe that we will ever be successful in finding comparable preventive measures in the field of mental health to those that have been possible in typhoid and other important physical diseases.

One of the accepted and widely used public health preventive techniques, when it is impossible to prevent the cause of certain diseases, is the building up of resistence in individuals against those diseases. For example, those of us who made the Sicily invasion with General Patton were given atabrine daily to build up our resistance against malaria.

Using this type of technique against mental disabilities of psychological origin, I have been working in the public schools of Delaware for a number of years with normal boys and girls ranging in age from 11 to 15 years. The purpose is to try to make these young people more emotionally robust, to help them progress toward emotional maturity.

The theory on which these human relations classes are operating is that little can be learned about personality problems except through emotional experiences and that ordinary teaching or lecturing or giving advice fall far short in providing the kind of insight that comes out of life encounters with emotional problems. While it is impossible to furnish children in classrooms with real life situations to discuss, to learn and to understand, our efforts and techniques are to endeavor to create as nearly as possible these actual "life situations."

In 1938 when I began experimenting with human relations classes as a positive mental hygiene program I based my procedures on the following assumptions:

1. The highest priority in education should be to help our boys and girls to learn how to get along well with themselves and with others.

2. Personality traits, good or bad, are learned skills. It is possible to help children from preschool age through junior high school develop desirable personality traits by setting proper examples for them and by encouraging them to practice desirable personality traits in place of undesirable traits.

3. If we start early enough it is possible to help normal boys and girls build more robust personalities—that is, to become more emotionally mature so that later in life when they are confronted with serious emotional problems they may be better able to cope with them.

4. The program should be aimed at normal children, not at children with deep emotional problems. We strive to help them learn more about the dynamic force of their emotions and to come to accept their individual emotional strengths and weaknesses.

5. The program must be conducted by those in daily contact with normal children, *i.e.*, teachers. We should start now, using our present teachers, training them as best we can, rather than wait for Utopia, when all teachers will have understanding insights into behavior problems.

6. Boys and girls make progress emotionally only by having emotional experiences. They gain insights only by having adequate opportunities to discuss such emotional experiences with understanding individuals.

Our weekly discussion class generally starts with the teacher reading a stimulus story that features emotional problems. The students are then encouraged to discuss freely the emotional problems presented in the story, to give an appraisal of the behavior of the characters, and then *most important of all* to indicate from their own personal ex-

[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N J., May 12-16, 1952.

[2] Founder of the Human Relations Class Program in Delaware.

periences parallel situations to those presented in the story. In this retelling of personal emotional experiences—often bringing out into the open problems they had never discussed before—a better understanding of their actions often results.

In our human relations classes we stimulate boys and girls to retell perplexing and disturbing emotional experiences. Many of them find to their surprise that their emotional problems are not unique, and they are often helped by the sympathetic advice of their classmates who have had similar experiences. They are helped by bringing their problems out into the open. Frequently some of the boys and girls who are hesitant in discussing their emotional problems and experiences in class are motivated to seek out an older person with whom to talk over their problems. These spirited discussions develop more understanding and sympathy among the members of the class and tend to make the class a more friendly, cooperative group.

In our fourth human relations class in the seventh, eighth, and ninth grades we ask pupils to indicate the members of their class whom they would choose as class leaders, social companions, helpers in school activities, etc. Ten simple questions are asked so that each member of class makes 10 decisions as to the others in class he or she admires or wants as associates or friends. Afterwards these 10 votes are tabulated for each member of the class. Results show that about 15% of the students in the average class receive no votes or perhaps only 1 or 2, while some members of the class receive as high as 50 votes.

In similar tests that are given in all grades from kindergarten through twelfth grade homerooms, we find that in each class about 15% of the boys and girls are socially unacceptable to their classmates. Apparently we are turning out of our schools about one out of 7 with whom the other students desire no social contact in school, on the recreational field, or at home. Up to the time the class acceptability records were made these overlooked boys and girls had not learned the fine art of making and keeping friends. Undoubtedly from these socially unacceptable boys and girls come many of our delinquents who seek asocial ways to obtain what they desire from life. Many of our seriously maladjusted also come from this group for our children growing up greatly need recognition; they need, above all, friends.

As we have studied the boys and girls overlooked in these acceptability records, we find that many of them are extremely shy or have unfortunate personality traits that can sometimes be changed by the sympathetic and understanding help of teachers and others interested. We are constantly searching for ways of giving these overlooked boys and girls some recognition in their classroom or extracurricular settings. We encourage their teachers to assign them class responsibilities and suggest they be on the alert to discover constructive ways of helping them become more accepted. Our class discussions frequently bring some of these overlooked children into more class prominence. Certain shy children experience feelings of success they have never known before. Boys with juvenile court records frequently make interesting contributions and thereby achieve their first classroom success.

In Delaware we have been working with boys and girls in the sixth, seventh, eighth, and sometimes ninth grades. At this period they are desperately attempting to change their personalities. They are at the peak of their enthusiasm and their compassionate interest in others. Because of our success to date we are not disappointed that we selected this age group to work with. We realize, however, that if our human relations program is to be truly successful it must be expanded to cover both lower and higher grades.

After twelve years' experience with the Delaware Human Relations Class Program we cannot prove statistically that the mental health of the people in our state has improved. Unfortunately we cannot boast that the boys and girls exposed to our classes have become more emotionally mature than boys and girls in other states. But we do know from letters of parents, from observations made by teachers and administrators, from statements of students themselves, and from our class acceptability records that progress is being made. School administrators inform us that many of the teachers engaged in our human relations class program have been decidedly

benefited. Many teachers have gained insights regarding the behavior problems of pupils and their own emotional behavior.

We have published 3 teachers' handbooks each containing 30 lesson plans and 6 teacher aids, giving complete information for conducting our human relations discussion classes. Only one book is needed by the teacher regardless of the number or size of her classes.

Our Delaware plan has extended to rural schools and to large city school systems in every state and every Canadian province, to Puerto Rico, to the Philippines, and even to 3 important demonstration schools in Western Germany. We estimate over 200,000 boys and girls in more than 7,000 human relations classes were using Delaware material this past school year.

Because of their interest in the program outstanding educators have traveled, sometimes at their own expense, long distances to participate in our Delaware teacher training programs. They have come from 18 states, gone back to their schools, and organized human relations classes.

The Mental Health Authorities in 14 states have shown their interest in our program by either sending selected educators to our Delaware human relations workshops or financing human relations workshops in their own states.

The main purpose of the Federal Mental Health Act is to prevent mental disabilities. Obviously if the Mental Health Authorities of the various states are to follow out the intent of the Federal Mental Health Act they must find ways and means of developing truly preventive programs in their states. Mental health clinics, necessary as they are, are not truly preventive because the individuals referred there are already in emotional difficulties.

Practical preventive measures in the field of mental health are public health and educational responsibilities, not psychiatric responsibilities. Educators and public health people have been reluctant to assume active leadership, as they have been informed too frequently by psychiatrists as to their lack of insight and understanding of emotional problems. At the same time psychiatry has not demonstrated real leadership in these so necessary preventive activities.

The average psychiatrist is not fitted by training or experience to operate effectively in the epidemiological approach necessary in successful preventive activities. We badly need all the psychiatrists we now have, and those who will be trained during the next decade, in their own clinical and treatment field.

Educators, because they have more frequent and more continuous contacts with normal boys and girls than does any other professional group, must take the major responsibility for directing and operating such preventive efforts.

Leaders in disciplines other than psychiatry should be urged by psychiatrists to develop experimental preventive programs in schools and communities. We in Delaware realize that our program is just "scratching the surface." Much more effective programs can be developed if we are able to appeal to the interest and ingenuity of leaders in other disciplines in the great challenge of prevention of mental disabilities and neurotic behavior. Of course psychiatrists should ever be ready to act as consultants.

ELECTROCONVULSIVE THERAPY FOLLOWING SURGICAL CORRECTION OF AORTIC COARCTATION BY IMPLANTATION OF AN AORTIC ISOGRAFT

A Case History [1]

J. VICTOR MONKE, M. D., Rochester, N. Y.

Unusual medical and physical complications in psychiatric patients cause the psychiatrist to question whether such complications contraindicate the use of electroconvulsive therapy.

Such a situation occurred at this hospital when a depressed man, age 36, presented the complication of a 6-cm. aortic isograft implanted one year earlier for the surgical correction of an aortic coarctation and aneurysm.

When evaluation studies enumerated below produced no reasons to the contrary, this man was given 15 electrically induced grand mal seizures without physical injury and with psychological benefit.

Survey of the literature reveals no other instance of the administration of convulsive therapy to a patient with an aortic implant. Recent reports of cases in which rare physical and surgical complications did not contraindicate electroconvulsive therapy include a patient who had a large portion of the cranial vault replaced by a tantalum plate(3), and a patient with an extremely severe kyphosis and scoliosis(2). Common contraindications of electroconvulsive therapy have been discussed by Kalinowsky and Hoch(1) and Williams and Barrera(4).

Presenting situation: Patient No. 97026 was a 36-year-old married unemployed machine operator and father of 3 children when he came to this psychiatric hospital on January 22, 1951, in a suicidal emotional state. One year previously he had undergone successful chest surgery for the correction of an aortic coarctation and aneurysm by implantation of an aortic isograft. Blood pressure values of 170-225/80-120 mm.Hg. in the arms and 80-90/0 mm.Hg. in the legs had been modified by surgery to normal values in the arms and 110-130/0 mm.Hg. in the legs.

From the patient's viewpoint, the surgery was unsuccessful for reasons given below. To this viewpoint he reacted with increasing frustration, anger, and depression.

[1] From the Department of Psychiatry, University of Rochester School of Medicine and Dentistry, Strong Memorial and Rochester Municipal Hospitals, Rochester, N. Y.

Since age 12, the patient is known to have had anxiety states. These worsened at ages 17, 22, and 28. Since age 28 such attacks usually began about 3 a.m. when the patient awakened with the sensation of a "golf ball size lump in the throat." This was followed by difficulty in swallowing and the development of a heavy painful feeling in the left precordium. The pain increased for several days, gradually to involve the left costal margin, the anterior upper left thorax, the anterior axillary fold, and the medial aspect of the left arm. Sometimes sharp stabbing pains were felt running from front to back through the left chest. Dyspnea, palpitation, tachycardia, episternal bulging, numbness, tingling in the left hand, pain and soreness in the left arm, as well as generalized sweating accompanied the chief symptoms.

Following a severe attack of anxiety at age 28 the patient was hospitalized and treated initially as having a myocardial infarction. Subsequently, x-ray films of the chest revealed typical rib markings of aortic coarctation. There was no indication that the coarctation was producing any subjective symptoms at that time. Electrocardiograms showed no cardiac pathology.

Thereafter the patient's emotional needs and the physicians' interest took divergent ways. On the one hand, the patient continued to have severe anxiety states every 6-12 months. Of these he had great fear and for them he desperately wanted help. On the other hand, a series of physicians objectively viewed with foreboding the eventual complications of the patient's coarctation, devalued those portions of his symptom-sign complex that did not result directly from the coarctation, and insisted that the patient have surgery.

The patient was fearful and unwilling to have the surgery. He doubted that he would be helped. It was as though he vaguely knew that the source of his symptoms were not in his chest but in his emotional adjustment. However, he was unable to communicate this fact. He was told that he would derive great benefit and increase his longevity to a normal life span if he had the surgery. The surgery came to mean to the patient that he would be well, and with such intellectual and emotional frames of reference he agreed to surgery in February 1950.

But, on the 13th postoperative day the patient had a typical anxiety attack! Subsequent to this he developed an intense rage toward his physicians. When he returned home he found himself unemployable at his former trade because medical examiners looked upon his large chest scar as a potential compensation problem. In subsequent months he became morose and acted out his troubles in his

home and in the community. When 4 months before admission to the hospital his wife had to go to work, he lost his chief claim to stature as a male. An incipient depression rapidly deepened to a psychotic level.

Therapeutic plan: Based on the genetics and dynamics of the patient's emotional illness, a plan was devised to treat his depression by hospitalization, to secure muscular rehabilitation through physical therapy and to achieve employability as soon after discharge as possible through the use of vocational rehabilitation agencies and conferences with the industrial physicians concerned.

Course in the hospital: Two weeks of hospital psychiatric care did not benefit the patient. Electroconvulsive therapy became the treatment of choice.

Now the staff were faced with the question, "Would grand mal seizures injure the aortic isograft?"

The following studies were applied to the problem: Physical examination demonstrated a blood pressure in the arms of 135/85 mm.Hg., and in the legs of 110/90 mm.Hg. The pulse was 95. The thoracotomy scar was well healed with no localized tenderness evident. The heart showed a slight enlargement to the left, and a soft blowing systolic murmur most evident over the mitral area; the aortic second sound exceeded the pulmonic second sound. There was no history of rheumatic fever. The dorsalis pedis arteries were palpable bilaterally. Routine laboratory studies of blood and urine were within normal limits. Electrocardiography indicated a sinus tachycardia. (In previous anxiety attacks paroxysmal auricular tachycardia was demonstrated.) Chest fluoroscopy visualized a left ventricular enlargement with prominent hilar shadows and prominent intercostal arteries. (The heart no longer impinged upon the esophagus as it had preoperatively.) Ballistocardiography registered irregular complexes with marked variation and low amplitude. Exercise tolerance studies indicated that the patient was susceptible to hyperventilation. This resulted in a physical fitness index of only 25-35% of normal. Radiography of the vertebra ruled out the presence of a cervical rib or abnormalities of the dorsal vertebrae. Surgical and orthopedic consultations gave the opinion that the aortic isograft was successful in its function and not vulnerable to damage by grand mal seizures.

Between the 23rd and 55th day of hospitalization 15 grand mal seizures were produced through electroshock. Each day the patient was seen psychotherapeutically in a supportive and superficially interpretive manner. Five days after the last seizure, he delivered himself of a tremendous outburst of anger toward family, doctors, and hospitals. Subsequently, he became less provocative, less guilty, and more cooperative.

Physiotherapy produced quite a marked increase in the patient's muscular strength and endurance through muscle training exercises.

The patient was discharged on the 68th hospital day. Shortly afterwards a restudy of the physical fitness index gave a value of about 50%.

Twenty-one days after discharge, with brief assistance from a vocational rehabilitation agency, and facilitated by conversations between the patient's physician and the industrial physician for one of the patient's former employers, the patient obtained employment in his trade. For the first time in months, he slept a night through without a large dose of paraldehyde.

Conclusion

Electroconvulsive therapy, producing grand mal seizures, has been successfully given to a patient with a 6-cm. aortic isograft of one year without evident injury to the isograft and with marked psychological benefit to the patient.

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A SIMPLE HYPNOTIZING TECHNIQUE WITH THE AID OF THE COLOR-CONTRAST ACTION[1]

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Customary hypnotizing techniques entail an element of risk. This applies both to the methods of verbal suggestion and to those of sensory stimulation (haptic, optical, acoustic, thermic, vestibular stimuli). The risk in question is specially inherent in the fascination method; in some cases the hypnotist may get tired before the patient does!

When the hypnotist looks into the patient's eyes or makes him stare at some brilliant object (e.g., a reflex hammer) while assuring him that he will fall asleep, there will be a double disappointment for the physician if the patient persists in remaining awake. In the first place he loses the confidence of the patient, who, rightly or wrongly, will think that he cannot hypnotize, and secondly, what is worse still, the hypnotist will lose the confidence in his own ability, which will adversely affect his self-assured attitude toward the patient with the well-known result: hypnosis is abandoned as a therapeutic aid. There is, however, a fixation method that is an exception to this, *i.e.*, the "color-contrast" method, the basic principle of which was laid down by Levy-Suhl in 1908.

Here follows a description of the technique of the method that we have applied for many years in the Leyden Psychiatric Clinic. The patient is asked to lie on a couch and is handed a piece of cardboard 14 x 23 cm, plain grey in color, on which 2 strips of paper, each measuring 3.2 x 8 cm and respectively light yellow and blue (not shiny), have been neatly pasted without any fold, in such a way that a space of 5 mm remains between the 2 colored strips. (The writer usually rounds off the bottom-right-hand corner of the piece of cardboard to prevent the sharp point from irritating the patient who holds it in his right hand.) The patient with normal eyesight is told to hold the card at arm's length.

The couch is placed in such a way that the light falls on the complementary colors. While the patient, in accordance with the instructions given him, fixes without interruption the slit between the 2 colored strips on the cardboard, he is asked about what exactly he sees there. He will naturally reply: "A piece of grey cardboard on which a yellow strip is pasted on the left, and a blue one to the right of it, with a grey slit between." The patient is told that, as he continues to watch the picture, especially the slit, he will soon observe some additional colors appearing. These chromatic phenomena, as a general rule, will be observed physiologically by any normal person, including the so-called "red-green dichromatics," and by all "anomalous trichromats"; they consist in the appearance of the respective complementary colors along the outside edges of the yellow and blue strips.

"When you have seen the color phenomena appear, that will be the proof that the hypnotic state is going to set in," I tell the patient. "In fact the appearance of the colors is the first sign of the effect of the hypnotic influence; it is a kind of fatigue phenomenon of the eyes," I assure him.

"In the same way as you have seen these color phenomena, you will observe some other signs of the approaching hypnotic state. Do keep looking at the slit; then you will soon see that the inner edge of the blue strip, that is to say, the edge bordering on the slit, becomes more intensely blue, while the rest of the blue strip will be a much duller shade. In precisely the same manner you will notice that the part of the yellow immediately bordering on the grey slit becomes more intensely yellow, while the rest of the yellow strip becomes more faintly yellow. Just keep watching sharply . . . . keep looking fixedly at the slit . . . . look very closely; you will see something else happen as well. You will also see colors appear in the slit; you will see a yellow border appear along the edge of the blue strip, and a blue border along the edge of the yellow strip. These two newly made colors will touch at about the center of the slit; now and then they will overlap; they may even disappear for a moment or two; perhaps because your consciousness is now beginning to waver, owing

[1] From the Psychosomatic Department of the Leyden State University (Chief: Prof. Dr. E. A. D. E. Carp).

to the hypnotic condition, which is on the point of setting in." I continue in this (purposely longwinded) strain.

Although the patient may perhaps feel somewhat skeptical at first toward this method of treatment, there is no doubt that by this time he will have abandoned this attitude; for he now sees before his eyes, point for point, that what is being told him is also actually happening, with the result that his confidence in the physician will increase correspondingly.

"You remember what I told you just now" (I continue very softly and monotonously) "that, as you observed the color phenomena, you will find that your eyelids are getting heavier and heavier . . . . still heavier all the time . . . . you will feel that you are getting more and more tired . . . . tired and weary . . . . and you will soon get so tired that you would just love to shut your eyes. When you feel like that don't resist . . . . don't resist . . . . you may close your eyes. . . . ."

The patient now reclines with his eyes closed; he breathes restfully as he would when asleep. He has dropped the hand holding the cardboard; I carefully take the cardboard from him, and say: "Just recline quite comfortably. Keep breathing deeply and regularly and only listen to what I am going to tell you now. You can hear me, of course, can't you?"—the patient whispers "Yes"—"all right then, listen. You are now in a sufficiently restful state for me to have a good influence on your mental and physical condition."

I continue in this strain, expressing different suggestions (all according to the case under treatment) in slow, soft but emphatic tones, stressing each word separately, and repeating the same things over and over again, using different words each time.

When the patient has spent, say, 15 minutes in this situation, I continue, " In a few moments I shall ask you to open your eyes and you will then feel absolutely fit and well; quite fresh, and without any traces of your former condition. Now when I say One, in a moment or so, you are going to feel that the fatigue and the drowsiness are sliding off you. When I say Two, you may open your eyes, and when I say Three, you will feel quite fresh and bright again." I now say [softly] "One; you are feeling the fatigue and drowsiness slipping away" . . . . I now say "Two [a little louder] and you may open your eyes again" . . . . and I now say "Three [in ordinary speaking voice] and you are feeling quite fresh again."

It often happens that a patient (although he may feel better after the hypnotic treatment) raises the objection that he did not, in fact, really sleep at all; that he heard and understood exactly what was said to him; that he was perfectly aware all the time of the place and the circumstances in which he was, but "nevertheless" feels it has done him good, "sleep or no sleep."

This remark on the part of the patient is on a par with the erroneous conception the average laymen has of the hypnotic state, which he usually regards as identical with deep sleep. For this reason it is necessary to point out to him that a person under hypnosis is in no way precluded from following and understanding exactly what happens around him or what is said to him. It should be stressed that the situation from which he has just emerged was definitely, both scientifically and practically, a "genuine hypnosis," so that he may confidently expect the treatment to be attended by success. This, after all, is what matters to him.

These objections on the part of the patient may also be countered by remarking that it was far from the doctor's intention to provoke the state of deep sleep, coupled with complete loss of consciousness, already at the first attempt at hypnotization, since that might have frightened him away from subjecting himself to further "experimentation." This, in fact, entirely agrees with our factual experience that to provoke a deep lowering of consciousness not only fails to produce advantage, but is, on the contrary, even undesirable in applying hypnosis therapeutically.

Only in those cases where this state is provoked for the purpose of studying psychosomatic phenomena can there be any necessity for producing a deep hypnotic state.

The working method here described has proved not only to yield beneficial results as a psychotherapeutic treatment, but in addition to be a valuable aid in psychosomatic investigation.

CASE REPORTS

SPECIFIC PRECIPITATING FACTOR IN AN ACUTE PSYCHOSIS [1]

NORMAN C. MORGAN, M.D., WARREN, PENNA.

That precipitating factors leading to an acute psychotic break may be specific appears exemplified by the catatonic schizophrenic reaction reported below:

The patient was a 30-year old white female, admitted August 25, 1951. The illness began in June of the same year. The first symptoms were confusion and irritability. Then she developed a fear that her brother, a priest located in a distant state, whom she greatly admired, would never see her again, that she would not be allowed to remain at the convent where she was a novitiate, and that her sacrifices were not as great as others. She wrote several confused letters to her priest brother. Subsequently she developed characteristic bizarre schizophrenic symptoms of symbolic meanings, distorted use of language, hallucinations of the Holy Ghost talking to her, and visions of the Holy Ghost, the Blessed Virgin, and the Child. Of specific interest was her belief that a hole being dug on the convent lawn was her brother's grave.

On admission to the hospital, she was alternately quiet and cooperative, and destructive, suspicious, and belligerent. She was alternately mute and voluble, manneristic and preoccupied. She attempted suicide by immersing her head in a bowl of water.

Electric shock therapy was commenced the fifth hospital day and she had 8 treatments in the ensuing 10 days with great improvement. Two weeks later her symptoms recurred and she received 20 additional electric shock treatments during the next 2 months.

She made progressive improvement during the ensuing months until leave of absence was granted in May, 1952. Except for external circumstances, she might have left the hospital sooner.

Understanding of the precipitating factors was gained when the patient was being considered for leave of absence. The question of the advisability of her taking final vows and the possibility of relapse were discussed. The patient insisted she felt relapse was impossible but was reluctant at first to substantiate her feeling. She asked for a detailed description of the onset of her symptoms which had never been given before. She seemed relieved and then provided the following analysis of her illness:

When she was about 14 years old she first had sexual relations with a brother (not the priest). Although both felt much guilt, this practice persisted over the next 11 years. At various periods one or the other would be away from home but incest would always recur when they were together. Finally her brother married in 1946, partially in order to break off the relations, and there were no further incestual desires. The patient became a novitiate in 1948 after making several efforts to join a religious order.

Throughout these years, she felt she should make confession of her sin, but could not make herself do so. She finally felt that the only priest to whom she could make the confession was her brother; also she felt the confession had to be made before she was to take her final vows in 1952. In June 1951, the priest-brother returned home for a visit affording the patient the only chance she would have for the confession before the final vows. However, the sin appeared so overwhelming to her that she still could not make the confession. The brother returned to his parish at the end of June, the patient having failed to discharge her self-imposed duty.

At this time, the confusion that had been mounting within her became obvious to others and resulted in her commitment 8 weeks later. She could not recall the first weeks of her hospitalization. She did recall the last several electric shock treatments. She said, "The last 3 weren't necessary. I was well then. When I came to I realized

where I was, I knew why—I knew I had to make that confession to get well. I told Father—[the hospital Chaplain] all about it. Ever since then I've known I was all right."

Her "feeling" that the burden of her sin was the cause of her illness amounted to conviction when she learned that the onset of symptoms actually coincided with her failure to make the confession to her priest-brother.

It is the writer's opinion that this acute illness was a disruptive response to a specific conflict, which has been largely eliminated as a potential source of future disturbance by confession and devotion to a religious life.

CORRESPONDENCE

PSYCHOLOGICAL REACTIONS IN AN EMERGENCY (EARTHQUAKE)

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: W.C. Menninger's report on the Kansas flood shows the great importance of collecting such observations. Despite old world experiences, we are in the dark as to the possible reactions of our population to grave emergencies of any kind. Therefore, we cannot have enough supplemental experiences from other catastrophes that may serve as test cases. We have every reason to revise the ominous predictions of our continental friends as to the ability of the civilians "to take it." While the Orson Wells prewar "invasion from Mars" broadcast was given undue publicity, reports on actual catastrophes should bear more weight.

The recent series of earthquakes in Kern County offered an opportunity for some additional observations to those mentioned in Menninger's report. Since the facilities of "about 100 trained psychiatrists" were not available here, the impressions of a single observer are naturally limited and personal. They can be compared with similar experiences he had on 3 continents during the last decades, including 2 world wars and the Sino-Japanese "incident."

On July 21, and again on August 22, Kern County experienced severe earthquakes. The first wrecked the business district of the small mountain town of Tehachapi and killed 14 people; the second apparently was concentrated on the downtown business district of Bakersfield, with the ensuing destruction of many older business buildings, requiring the temporary roping off of 68 city blocks. The loss of life was miraculously minimal in spite of the rush hour and the collapse of many walls and roofs. While the first quake occurred in the early morning (about 5:00 o'clock), the last one took place in the midst of a busy afternoon at 3:30. There were numerous after-temblors and minor shocks between July 21 and August 22 and since then. These were the first major earthquakes in the history of Bakersfield since its founding around 1860. The Greater Bakersfield area has a population of approximately 115,000 and is a flourishing agricultural and oil center.

The first earthquake caused tremendous damage to the 25-year-old county hospital. Three-fourths of its facilities had to be evacuated. A great number of public buildings, the City Hall, the Court House, and numerous public schools, which had suffered from the first quake, were damaged beyond use by the second major shock, later requiring demolition. There are cracks in the walls and ceilings of practically every building in the city.

Five minutes after the August 22 shake, I was called to the collapsed structure of the Kern County Equipment Company, which offered a sight of rubble and debris comparable to a blitz. While the crews were working on all sides to rescue missing people from under the debris, including one fatality, there was no panic. At that time the total loss of human life was believed to be much higher than it later fortunately proved to be. A woman running out of a downtown store was killed by a falling wall. There were many individual cases of calmness. One office girl, for example, took her typewriter from the cracked administration building of the local college during the second quake and continued her typing on the lawn. (She was doing a report of the damage of the first quake.) Temporary discontinuation of electricity made clear the value of portable radios in such emergencies. The remarkable preservation of their composure by individuals, by and large, throughout the community (whether it was on the surface or not) was no doubt due to the conditioning of people by the first earthquake and the subsequent temblors. There has been no exodus to any extent from this community, except for some migratory workers who left in a hurry. The disruption of public life due to the destruction of churches and schools (200 classrooms were condemned) was and still is more serious than at first appeared.

Rumors and fears, of course, turned up immediately. After each quake, supposed announcements of further severe shocks to come were circulated. Dust rising from the nearby Tehachapi mountain range was interpreted as a reactivated volcano. A most sensible denial from the local press immediately dispelled any further spreading of such stories. As a cross sampling, I compiled some statistics and found that 19 of a group of 25 adults did not know that earthquakes are followed by after-temblors for a considerable length of time. Fifteen were convinced that the earth might open up and swallow houses, men, and beasts, then close again. This is a wide-spread belief, although such an occurrence has never been seen during the last 2 centuries in any part of the world where earthquakes are extremely common and well observed (Japan, India, etc.). Manifestations of hypomanic exhilaration by unharmed survivors were evidenced in the population in the form of silly jokes ("Quakersfield"), and a stream of out-of-town sightseers the following Sunday who thoroughly enjoyed other people's distress. A well-intentioned lady characterized the regular midnight after-temblor as "Old Faithful", and the morning after-temblor as "Big Ben." This grim humor ("gallows humor") after severe shocks deserves further investigation.

It seemed impossible to avoid exaggerations in both directions. The sensational overdoing of some outside press reports was matched by the understatement of a well-meaning counselor who tried to explain away actual continued after-temblors as the feeling of shakiness of anxious persons. A Fresno newspaper, in an editorial, made the highly questionable statement that what happened to Bakersfield could never happen to their city. Whether it was necessary and wise in a time of excitement to hurriedly fire a hundred employees no longer needed for the shrunken county hospital might be a matter of discussion.

The effect of catastrophes as reflected in private practice, although probably neither new nor original, still deserves mention: The nice differentiation between anxiety and fear, as found in our textbooks, can hardly be upheld by anybody observing their fusion in emergencies. In general, the relatives of many psychiatric patients were much more upset than the patients themselves. However, the precipitating factor for psychotic reactions appeared very likely in a businessman who lost all his property and responded with an acute severe depression that he had experienced a few times previously in his life. A paranoid patient confiscated a car in order to go and save the hard hit mountain town of Tehachapi after the first quake. A young woman of 27 years with a severe anxiety neurosis, who had undergone the London blitz, collapsed and expired after a minor after-temblor. The post-mortem did not show sufficient findings to explain her death, which may belong to the highly controversial group of psychogenic cardiac deaths.

There was a new awareness among people when the beautiful security of everyday life was shaken. The experience of human frailty needed no existential explanation. This city knows that neither the occurrence of earthquakes nor their disappearance can ever be predicted: "the readiness is all."

In this preliminary communication, no further details can be given at present. I wished to report on the remarkable strength of resistance in general by a medium-sized typical American community, which rallied to reconstruct their hard-hit city immediately after the disaster. We need not be too pessimistic about the resources of our population under stress, which can compare with the fortitude of any other nation at any time.

RICHARD D. LOEWENBERG, M. D.,
Bakersfield, Calif.

PRESIDENT'S PAGE

THE COMMITTEE STRUCTURE OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Of all the policy decisions made within The American Psychiatric Association, probably none has been more momentous and has had more far-reaching consequences than the decision to shift the Association from the status of an organization primarily active only at the time of its annual meeting to the status of one continuously at work throughout the whole year. And in the implementing of this decision the committees of the Association have played a most notable part.

It is true, of course, that to bring about so fundamental a change in the life of the Association a great series of shifts had to be worked out and new key developments fostered. The setting up of the Medical Director's Office was one of these; the decision to bring out the JOURNAL on a monthly, rather than a two-monthly, basis was another; and a most sensible increase in the amount of work transacted by the Council and by its Executive Committee was still a third.

This policy decision to move over to a basis of continuous action through the year, which had been maturing in the minds of the membership over a considerable period, was the outcome of a realization that we had a growing responsibility to give public leadership in the maintenance and enhancement of the psychiatric health of the populations that we served.

There has also been an increasingly firm conviction that our contributions must take the form not only of our specialized knowledge but also of the leadership that we can give to organizations such as those concerned with recreation and rehabilitation, to key social institutions such as those of the law and of education, and to the public in general.

Hence the Association has turned to the tremendous and growing reservoir of skill and capacity that it has in its wideflung membership. This most crucial problem has engaged our attention now over many years—how to mobilize the immense potential resources of our membership in a way that will be at once majorly economical and maximally effective.

This recognition of the dynamic and leadership role of the Association in the life of our times has hammered out a series of changes in our concept of the work of the individual committee. Dr. W. C. Menninger, chairman of the Coordinating Committee on Community Aspects, in a recent communication has stated this with clarity and with force. He says: "I feel that the basic problem of what is the function and responsibility of a committee can be simply stated in two areas: (1) to give leadership to the members of the Association in its field of activity; (2) to give psychiatric leadership to interested individuals, groups, and movements outside of the organization related to the committee's field of activity. This is almost a presumptuous assignment, if we were to assume that only 5 members in an organization of 7,000 in a population of many millions of people could be very effective by themselves. Therefore, I think your thought of extending as rapidly and as effectively as we can the coordinated planning, actions, and implementation of any one committee's activities through our district and affiliate society groups is a good one. It is a very real problem as to how much leadership a committee can give because of limitations of man power and time."

This widely accepted concept of the function and responsibility of committees has in turn led to a great deal of thought and planning, which may be briefly considered in 3 major areas, as follows.

1. The strengthening of the internal effectiveness of each committee. After considerable trial and error, 6-member committees have been found most effective, save in special circumstances. The extremely difficult question of whether that membership should be drawn from a fairly limited locality so that the members can readily get together, or whether the membership should

be set up on a geographically representative basis, has found some measure of solution insofar that where it is of prime necessity that contact should be maintained with our whole territory—as in the case of the Committee on Membership, or the Program Committee—a geographical plan has been followed; but where it is of more importance that quick decisions should be achieved, then there has tended to be some concentration of the membership of the committee in a more limited region.

Many suggestions have been brought forward for increasing the working power of a given committee, among them being that a committee should have permission to set up correspondents or associates. This has generally been regarded favorably, provided these additional individuals are not considered official members of the committee and provided their appointment follows routine channels. A proposal that is being actively pushed at the present time is that the standing committees should endeavor to work in the closest possible relationship with the committee structure of the district branches and affiliate societies. These bodies have been increasing in number with remarkable speed, particularly since the war, and a number of joint meetings of the representatives of the standing committees and of the district branches and affiliate societies have been held, with more meetings planned. Dr. William Malamud, chairman of the Coordinating Committee on Technical Aspects, has recently advanced the suggestion that representatives from the district branches and affiliate societies should be asked to attend the meetings of the Coordinating Committees that are held at the time of the annual meetings of the Association and that represent a general review of the work of the whole bloc of committees. It is felt that if a satisfactory working relationship can be established between these 2 exceptionally important divisions of the Association—namely, the standing committees on the one hand, and the committee structure of the district branches and affiliate societies on the other—a powerful increase in effectiveness of the work of the Association can be anticipated.

The perennial question of the financing of the committees is still largely unsolved. The Council has now approved a policy whereby, with its sanction, an individual committee can seek funds from a foundation or other source for a Council-approved project. This is a plan that has been successfully executed by a limited number of committees; there is no doubt that it could be very greatly expanded. Our Medical Director, Dr. Daniel Blain, is currently urging that standing committees should consider the possibility of setting up their work, in part or whole, in the form of 3-year projects for which financial support could be sought from a foundation or other source.

2. Methods of integrating the work of the committees with each other. Subsequent to World War II there was a rapid expansion in the number of committees, and within a very few years it became impossible for these committees to have their individual reports fully assessed by Council at its regular meetings. Moreover, it was felt that a considerable degree of overlap in the work of the committees was beginning to appear. A Committee on Committees was set up, the terms of reference of each committtee were set after consultation, and the merging of a limited number of the committees was advised. An important development was initiated by Dr. J. C. Whitehorn in the form of grouping the committees into 3 main categories: namely, those concerned with the Community Aspects, the Technical Aspects, and the Professional Standards, of psychiatry—the remaining committees being left ungrouped and described as "Housekeeping Committees." This integration of the committees under coordinating chairmen who have had previous experience on Council has resulted in the possibility of Council giving much more effective consideration to the recommendations submitted to it by the committees at the annual meetings, and has resulted in a general increase in the incisiveness of the atttack being made by the committees on their problems.

3. The application of the recommendations and plans produced by the committees. This third area is being given active consideration by Dr. F. J. Braceland, chairman of the Coordinating Committee on Professional Standards, thought being specially directed to-

ward the possibility of abstracting any essentials of the committee's report and finding a medium whereby they can be presented to the membership as a whole. This matter has its counterpart on a still larger scale, for if our leadership is to be truly effective we must find ways of uniting our efforts with those of forward-looking individuals and groups in our great social institutions of law, of education, and of health. There is already a great and growing demand for our reports from many bodies, not only in the countries that we immediately serve but in many other countries across the world. There is a demand for leadership from service clubs, from national recreational groups, from those concerned with legal reforms, from the armed forces, and, indeed, from the whole range and complexity of the rapidly evolving institutions that are weaving the texture of the quick-forming patterns of our days.

The picture of the committee structure of The American Psychiatric Association is incomplete without reference to the work of the *ad hoc* committees and the special boards, but the proper limits of this page preclude more than their mention.

D. Ewen Cameron, M. D.

MADNESS

We are all mad in our dreams, when outer impressions do not check our galloping ideas; and marginal madness plays about us in our waking thoughts; as a dog will scurry before and behind his pedestrian master and is whistled for sometimes in vain. Great passions and excitements touch madness at their summit: so that madness is not really an inhuman or demonic thing. It is only too domestic, too individually human, too headstrong to keep in step with things; so that if it becomes central and directive, it dashes us against the rocks. Not always, however, so soon or so fatally as a summary view might suggest. A boat may lean over very far in the wind without capsizing, when there is ballast and momentum enough; and a mind can yield to a vast deal of extravagance without coming to grief.

—Santayana

COMMENT

SIR CHARLES S. SHERRINGTON

A Tribute

Sir Charles S. Sherrington died on March 4, 1952, at the age of 95 years. No man in the modern history of medicine has had so great an influence on the development of neurophysiology and the understanding of clinical phenomena that occur in patients with lesions in the nervous system. Many honors were bestowed on this quiet, shy, retiring scientist. He was the Nobel Laureate for Medicine in 1932, and his many scientific achievements were recognized by the awarding of honorary degrees by universities throughout the world. He was awarded the Royal and Copley Medal of the Royal Society, the Hughlings Jackson Medal of the Royal Society of Medicine, the Retzius Medal of the Swedish Royal Academy, and the Baly Gold Medal of the Royal College of Physicians. He was elected to honorary membership in many foreign medical societies.

Sherrington was born in London on November 27, 1857, and received his education at Cambridge. His academic appointments included those of professor of pathology at the University of London, professor of physiology at Liverpool, and professor of physiology at Oxford. He held the latter chair from 1913 until his retirement in 1935.

Sherrington was attracted to neurophysiology at the onset of his career by the experimental studies of Fritsch, Hitzig, and Ferrier. His first published works were studies of the nervous system of decorticate dogs. Among the more important of his physiological studies were the following: the peripheral distribution of the posterior roots of spinal nerves; the identification of proprioceptive endings in muscles; the ataxia and loss of tendon reflexes secondary to section of the posterior roots; the analysis of decerebrate rigidity; and the elucidation of the concepts of the synapse and the stretch reflex. So many of the facts that Sherrington discovered by painstaking investigation are taken for granted at present that it is difficult for students to realize these facts were entirely unknown less than 50 years ago.

Sherrington was a versatile man. He was a philosopher, teacher, and student of poetry, art, and the cultural background of medicine. His name will be immortal because of the great advances he has made in our knowledge of the physiology of the nervous system.

H. Houston Merritt, M. D.

CURRENT CONCEPTS OF OCCUPATIONAL THERAPY

As it is practiced in the psychiatric hospitals of this country, occupational therapy varies greatly, not only from one institution to another, but even within one hospital. This comment is not intended as a ready reference on the proper use of such treatment. It is but a clarifying statement for psychiatrists who have not had the opportunity of observing an occupational therapy program dedicated to meeting specific emotional needs of patients through activity. That such an orientation is desired shows occupational therapy to be a rapidly maturing young profession: young because its variable standards are partially the result of a membership that includes those originally qualified on the basis of experience or very limited training; and maturing because it has the assurance essential to critical self-evaluation.

There seem to be two common points of confusion as to the nature of occupational therapy. There are those who think that it is "keeping patients busy," and others who identify it with the production of hand work. Both of these objectives have their place, but as ends in themselves they represent a misconception considered outgrown by those well oriented in the field. "Busyness" can be

therapeutic, but only when the activity establishes a new and healthier pattern of behavior. This may be accomplished through pleasant relationships and the elimination of factors threatening to the patient. It may result also from the patient's ability to sublimate his problem-creating needs in the activity provided; specifically, occupational therapy is often of great value in helping the patient to handle hostile and erotic drives. Making something that is beautiful or useful is satisfying to everyone, but it is occupational therapy only when its production is planned to enable the patient to think better of himself, and to relate in an improved manner to his instructor, to those who admire the project, or to the person to whom he gives it. The aim of occupational therapy is thus defined as a technique to produce healthier behavior, and improved interpersonal relationships, through the medium of planned activity.

Any program of intensive psychiatric treatment is determined by the nature and needs of the individual patient. So it is with occupational therapy in the active treatment unit. It is, as we conceive it, dependent upon the psychiatrist. He provides us with the essential clues to our role in meeting the psychological needs of the patient; or, where the treatment is planned by the team, the doctor is the keystone of that team. The occupational therapist cannot fulfill his part of the treatment program effectively without knowing the needs of the individual patient. They determine the selection of activity, the approach to the patient, and the management of the interpersonal situation. Activity blindly promoted may frequently have ameliorative effects but since such effects are accidental it can hardly be called "therapy."

Therapeutic activity can provide a variety of experiences to meet specific needs. The project that fails may have more therapeutic value than one successfully completed. In such an instance the hostile patient, for example, may not only obtain catharsis from aggression so expressed; but may, under the guidance of his psychotherapist, gain insight into this hostility. In some instances the nature of the activity itself is an essential part of treatment. The feces smearer who is encouraged to do finger-painting may find the acceptance he needs implicit in this activity. On the other hand we expect finger-painting to be very disturbing to a compulsive patient. Thus we see the importance of selecting a medium to fit the needs of the individual patient. The pliability or resistance of the material, the freedom or precision of movement and of attention, the amount and direction of force, the dirt and noise involved are some of the factors in activities that provide varying emotional experiences.

Perhaps the most important part of occupational therapy, however, is the opportunity for the manipulation of interpersonal relationships as indicated in the individual case. The occupational therapist may permit a wide latitude, or expect the patient to toe the mark; he may place the patient in a group situation, permit or offer isolation, or assign him to teach a sicker patient. The activity provides a normal situation for give and take, for accepting guidance, or lending a helping hand. Conversation develops naturally and may be used to extend the patient's horizons. Activity is the laboratory in which the patient can try out what he learns in psychotherapy. It is the duty of the occupational therapist to temper the reality situation to the tolerance of the individual; to see that the tentative gesture of a frightened patient is not rebuffed, or that the convalescent patient is not overprotected.

Occupational therapy can provide a controlled environment adapted to meet individual experiential needs. The patient may spend as much as 6 hours a day in this milieu. The occupational therapist is keenly aware that occurrences in that period may reinforce or sabotage the psychotherapeutic work of the psychiatrist. The competent modern occupational therapist is prepared and wishes to play a supporting role to the psychiatrist, to take his or her place as an effective member of the treatment team.

It is the thesis of this comment that occupational therapy can and should be an effective and integral part of the treatment program in psychiatric institutions.

ELIZABETH P. RIDGWAY, O.T.R.

NEWS AND NOTES

DR. HELDT RETIRES.—Dr. Thomas J. Heldt, who 29 years ago organized the psychiatric service at Henry Ford Hospital in Detroit, retired as the active head of this division July 1, 1952. In this pioneer work Dr. Heldt set up a service for all types of psychiatric cases as an integral part of a general hospital in a ward for both men and women in all respects similar to the other medical wards of the hospital. Patients were received without legal formalities, on the same basis as other patients, and transfers in both directions between the psychiatric and other wards were freely effected as circumstances indicated.

Dr. Heldt's pioneering service constituted a landmark in administrative psychiatry and became a pattern for other hospitals to follow. The conditions of care and treatment that he established brought the hospital management of psychiatric cases as near to the ideal as one can readily conceive. Ford Hospital will still have the benefit of his experience and wisdom as he will remain on the staff as Senior Consultant.

DR. PROCTOR HEADS NEUROLOGY AND PSYCHIATRY AT HENRY FORD HOSPITAL.— Dr. John G. Mateer, Physician-in-Chief of Henry Ford Hospital in Detroit, has announced the appointment of Dr. Lorne D. Proctor as Physician-in-Charge of the division of neurology and psychiatry at the Henry Ford Hospital to succeed Dr. Thomas J. Heldt, effective July 1, 1952. Dr. Proctor, a graduate in medicine of the University of Toronto, was for a considerable number of years associated with the University both in the department of psychiatry under Dr. C. B. Farrar and in the department of medical research under the late Sir Frederick G. Banting. He had also organized and directed a very active service in neurology and psychiatry as attending staff physician at the Toronto Western Hospital.

From a number of possible appointees Dr. Proctor was selected as the one best equipped to assume the heavy duties of his new position and carry forward the high traditions established by his predecessor.

"MY NAME IS LEGION."—Audiences in 15 states are having the opportunity of seeing this play based on Clifford Beers' book, "A Mind That Found Itself." The play had its first performances with an all-Broadway cast last spring and is now on the road for a 7-week tour. It was written by Nora Stirling of the American Theatre Wing and Nina Ridenour, director of education of the National Association for Mental Health, and its production is a joint enterprise of these 2 organizations.

The road show, which has scheduled 41 performances in 38 cities, will serve as a preview of the 1953 campaign of the National Association for Mental Health.

RORSCHACHIANA.—The irregular publication under this title has now become a quarterly journal published in Switzerland. It will contain papers in English, French, German, and Latin. An international committee assists the editor, K. W. Bash of Zurich. *Rorschachiana* is intended to provide an international forum for research in personality, assisting in the exchange of facts and theories between serious investigators in all lands and schools. Yearly subscription is S. Fr. 30. The distributor for the United States is Grune & Stratton, New York.

FACTS ABOUT PSYCHIATRIC NURSING.—Although psychiatric hospitals have 54% of all hospitalized patients, only 5% of all professional nurses are employed in psychiatric hospitals. This fact and others of equal interest are contained in a League Letter published by the National League of Nursing Education (No. 34, May 28, 1952). In addition to statistics the Letter reports what nursing schools and the League are doing to provide learning experiences in psychiatric nursing. The entire issue is devoted to this subject.

NEW CHILDREN'S UNIT IN MINNESOTA.—The University of Minnesota Hospitals on October 1 opened a new 24-bed unit for psychiatric services to children. This is the only such facility in the state. Dr. Reynold A. Jensen, professor of pediatrics and psychiatry, is medical director, and the unit will operate as a part of the department of pediatrics.

Although pediatric service in psychiatry on an outpatient basis has been in existence at the University since 1938, previously the only place for the hospitalization of a seriously disturbed child was in the psychiatric unit for adults or in the pediatric unit. The new facility will provide for better patient care, including special therapies, and more adequate opportunity for training of personnel.

The unit was made possible as the result of a $115,000 grant from the 1951 state legislature for the 1952-1953 biennium.

PSYCHOLOGICAL FUNCTIONING FOLLOWING CEREBRAL HEMISPHERECTOMY.—Mensh, Schwartz, Matarazzo, and Matarazzo report in the *Archives of Neurology and Psychiatry,* June 1952, a case of a man aged 54 in whom the entire right cerebral hemisphere was removed on account of extensive brain tumor. Because of the sequelae of the radical operation psychological tests could not be begun until the 18th postoperative day. During 5 months following the operation various tests (Wechsler Memory Scale, subtests of the Wechsler-Bellevue Intelligence Scale, Rorschach) were administered. They indicated wide variations in function, perseveration of ideas, confused and psychotic-like thinking, sound (*klang*) associations, mingling of old and new information, and self-reference. Premorbid verbal facility and compulsive behavior were also evident.

In view of the fact that in the relatively few reports of hemispherectomies pre- and postoperative psychological functioning has usually been described only in general terms and that a number of reports have emphasized the absence of psychological disturbances following hemispherectomy, the present report, which reflects "extreme variation and disturbance in the psychological functioning after operation," indicates more careful postoperative study in similar cases in the future.

ICHTHYOSIS TREATED BY HYPNOSIS.—A. A. Mason, M.B., B.S., reports in the *British Medical Journal,* August 23, 1952, the results of hypnotic treatment of congenital ichthyosis in a boy aged 16. All other forms of treatment had been of no avail. The lesion covered the entire body except the chest, neck, and face, being worst on the hands, feet, thighs, and calves and least on the upper arm, abdomen, and back. There were no other evidences of congenital deformities and no family history of ichthyosis. In skin graft experiments apparently normal skin from the chest grafted onto palmar surfaces promptly became as ichthyotic as the original skin.

Under hypnosis (February 10, 1951) suggestion was made that the left arm would clear. About 5 days later the horny layer softened and sloughed off. "At the end of 10 days the arm was completely clear from shoulder to wrist." Marked areas of clearing followed successively in other areas following hypnosis. Clearing in different areas ranged from 50% to 95%.

"Whereas during the first few weeks clearance of the affected areas was rapid and dramatic, during the last few months there has been no appreciable change. There has, however, been no relapse of the improved areas over a period of one year."

Commenting on this and other reports of psychological factors in dermatoses B.M.J. remarks editorially, "The important role of the ectoderm in the lower forms of life, its contribution to the central nervous and endocrine systems in the course of development and evolution, and its significance in relation to adaptation to environment all suggest that it may retain such an intimate relationship with the essential springs of life as to be part and parcel of the personality of the individual, readily participating in his emotional health and behaviour." B.M.J. emphasizes "the great need for further basic scientific work on the relation between the mind and the skin."

CREEDMOOR INSTITUTE FOR PSYCHOBIOLOGIC STUDIES.—Dr. Harry A. LaBurt,

senior director of Creedmoor (N. Y.) State Hospital, announces renewal of a contract between the Creedmoor Institute for Psychobiologic Studies and the Atomic Energy Commission for the study of the relationship between skin groups and blood groups. This project is under the direction of Drs. Co Tui; Arthur Mortimer, and Raymond Sackler; and Harry A. LaBurt, and the administrative supervision of the Department of Mental Hygiene. It has been in operation since September 1951.

NEW YORK ACADEMY OF MEDICINE EDUCATIONAL PROJECT.—Dr. Robert L. Craig, executive secretary of the New York Academy of Medicine Committee on Medical Education, reports that the Academy has joined with the Commissioner of Mental Hygiene of New York State, Dr. Newton Bigelow, in a project to improve the educational opportunities and facilities for the resident staffs of New York State mental hospitals. The Academy of Medicine, through its Committee on Medical Education, has appointed a subcommittee on the study of professional services for mental hospitals of New York State to cooperate in this effort.

In order to collect information and to determine the number of potential teachers for this project, Dr. Thomas A. C. Rennie, a member of the subcommittee, has prepared a questionnaire, which has been approved by the Commissioner and sent to all psychiatrists in New York State who are listed in the Directory of the American Psychiatric Association. Physicians are assured that answering this questionnaire in no way commits them to participation in the teaching plan, but it is felt that the information reported will prove most useful to the Academy and to the Commissioner in carrying out this important professional educational program.

THE WOODS SCHOOLS.—Mrs. Mollie Woods Hare, who founded the Woods Schools at Langhorne, Pa., for exceptional children in 1913 and became first president, and who in 1948 presented the institution as a gift to the Board of Trustees in order to ensure indefinite continuance of the Schools, is retiring as president and has been elected honorary president.

Mr. Edward L. Johnstone, an administrator of 28 years' experience in the training and education of the mentally handicapped, has been elected president of the Woods Schools and will enter upon the duties of this office early in January 1953. Mr. Johnstone is a member of the U. S. Attorney General's Conference on Juvenile Delinquency, a consultant on the Educational Policies Commission of the United States, and a member of the Board of Trustees of the Vineland Training School at Vineland, N. J.

The Board of Directors also announced the appointment of Dr. Leslie R. Angus as resident psychiatrist and director of the Child Research Clinic. Dr. Angus was formerly director of psychiatric services at the Devereux Schools, Devon, Pa., and is an instructor in psychiatry at Columbia University and at the University of Pennsylvania.

ISAAC RAY LECTURES.—Dr. Winfred Overholser, superintendent of Saint Elizabeths Hospital and professor of psychiatry, George Washington School of Medicine, Washington, D. C., will deliver the first series of Isaac Ray Lectures on psychiatry and the law at Harvard University, with topics and dates as follows:

The first two lectures of the series, on "The Substance of Psychiatry" and "Differences of Viewpoint," will be presented in the Courtroom at Harvard Law School at 4 p.m. on November 13 and 14. The remaining two, on "The Mental Patient and the Hospital" and "The Psychiatrist as Witness," will be given at 5 p.m. on November 17 and 18 in Amphitheatre D at Harvard Medical School.

VA COURSE IN PSYCHIATRY AND NEUROLOGY.—Vice Admiral (M.C.) J. T. Boone, Chief Medical Director of the Veterans Administration, announces the institution of a 4-month intensive training course in psychiatry and neurology to fit the needs of physicians without such previous training who are assigned to duty in 22 predominantly psychiatric hospitals operated by the Veterans Administration. Physicians who have been engaged in general practice may request this training upon applying for a position at one of these hospitals.

The course will be held at the VA Hos-

pitals in Coatesville, Pa.; Palo Alto, Calif.; and a joint Downey-Hines, Ill., program near Chicago. Physicians will be employed at salaries commensurate with their training and experience (salary range: $5,500 to $11,800 per annum) and assigned to the course with travel and per-diem expenses for the 4-month period.

Information and application forms may be obtained from the nearest VA Hospital or Regional Office, or by writing to the Chief Medical Director, VA Central Office, Washington 25, D. C.

NORTH SHORE HEALTH RESORT LECTURES.—The Third Annual Lecture Series sponsored by the North Shore Health Resort, Winnetka, Ill., will be held October through June on the first Wednesday of each month (second Wednesday in May) at 8 p.m. at the Health Resort. There is no charge for these lectures, and all physicians of the Chicago area are invited to attend. For program or other particulars address the Medical Director, Dr. Samuel Liebman, 225 Sheridan Road, Winnetka, Ill.

MEDICAL CORRECTIONAL ASSOCIATION.—This Association met in Atlantic City, N. J., October 7 and 8. In addition to considering various aspects of prison therapy and psychological characteristics of offenders, the program presented a summation of two years' experience with the new Federal law concerning mental competency. The October 7 session was a joint meeting with the Correctional Education Association and the Correctional Service Associates.

Dr. Sara G. Geiger is president of the Medical Correctional Association; Drs. Edward C. Rinck and Otto L. Bettag, vice-presidents; and Dr. Ralph S. Banay, secretary-treasurer. Councillors are Drs. Justin K. Fuller, Frank J. Curran, Stanley E. Krumbiegel, and Lowell S. Selling.

MORENO INSTITUTE.—Chartered by the Board of Regents of the State of New York as a nonprofit institution, the Moreno Institute offers postgraduate courses in psychodrama, sociodrama, role-playing, sociometry, and group psychotherapy. The objectives of the Institute are to develop operational standards in the use of these methods and to encourage research in their application. Among the members of the faculty and lecturers are Ordway Tead, J. L. Moreno, Robert Boguslaw, and Jacob Greenberg.

For complete information, write for catalog to Moreno Institute, Room 327, 101 Park Ave., New York 17, N. Y.

CENTRAL CALIFORNIA PSYCHIATRIC SOCIETY.—On September 13, 1952, was organized the Central California Psychiatric Society, which will have as members those psychiatrists who are serving the Sacramento and San Joaquin Valleys of California. There are about 40 men doing psychiatry in this area, which serves 1,600,000 people. Membership will be limited to members of The American Psychiatric Association.

The officers are Dr. Mark Zeifert, of Fresno, president; Dr. Rudolph Toller, of Stockton, vice president; and Dr. Vayle S. Briden, of Fresno, secretary-treasurer.

AMERICAN ACADEMY OF FORENSIC SCIENCES.—This Academy announces its fifth annual meeting, to be held February 26-28, 1953, at the Drake Hotel, Chicago, Ill. All persons planning to present papers should submit their titles to Dr. Milton Helpern, program chairman, 106 E. 85th St., New York 28, N. Y., before December 1, 1952.

SOCIETY FOR THE ADVANCEMENT OF CRIMINOLOGY.—This Society will hold a one-day interim meeting on February 24, 1953, at Northwestern University Law School, Chicago, Ill. This meeting will immediately precede the 1953 meeting of the American Academy of Forensic Sciences announced above. It will be of interest to all those engaged in police administration programs on the college level who have not been able to attend the annual meetings in California. The complete program will be announced shortly. All those interested in presenting papers should address the program chairman, Prof. Ralph F. Turner, Department of Police Administration, Michigan State College, East Lansing, Mich.

ASSOCIATION FOR RESEARCH IN NERVOUS AND MENTAL DISEASE.—The 1952 annual meeting of this Association will be held on December 12 and 13 at the Hotel Roosevelt, New York City. The subject of the meeting will be "Metabolic and Toxic Diseases of the Nervous System."

Officers of the Association are as follows: Dr. H. Houston Merritt, president; Dr. Robert F. Loeb and Dr. Charles D. Aring, vice-presidents; Dr. Clarence D. Hare, secretary-treasurer; and Dr. Rollo J. Masselink, assistant secretary.

AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION.—The tenth annual conference of the Association will be held January 9 and 10, 1953, at the Henry Hudson Hotel, New York City.

Six panel meetings dealing with group psychotherapy in (1) general hospitals, (2) child guidance, (3) private practice, (4) correctional institutions, (5) mental hospitals, (6) related fields, are announced. Brief summaries of the panels will be presented at the concluding sessions.

Dr. Lewis H. Loeser is president of the Association, and Dr. Bertram H. Roberts is chairman of the education committee. Inquiries may be addressed to American Group Psychotherapy Association, 228 E. 19th St., New York 3, N. Y.

How can we say that a scientific concept, to which we now ascribe an absolute character, may not at some future date show itself to have only a certain relative significance and to point to a further absolute? To that question only one answer can be given . . . . we must admit that in no case can we rest assured that what is absolute in science today will remain absolute for all time. Not only that, but we must admit as certain the truth that the absolute can never finally be grasped by the researcher. The absolute represents an ideal goal which is always ahead of us and which we can never reach.

MAX PLANCK.

BOOK REVIEWS

BEHAVIOR PATHOLOGY. By *Norman Cameron, M. D., Ph. D., and Ann Magaret, Ph. D.* (Boston: Houghton Mifflin Company, 1951. Price: $5.00.)

Here at last is a readable book, well written in common-sense, understandable language that is yet scientifically sound and completely free of mythological interpretations. From a rich background of academic training and medical practice, a psychiatrist who also holds a psychologist's degree and an experienced clinical psychologist discuss interestingly and logically the behavior of human beings as determined by biological make-up and modified by participation in family life and that of social groups.

Not only psychiatrists and psychologists, but general practitioners, psychiatric social workers and well-educated laymen can understand and use constructively the knowledge gleaned from this scholarly textbook.

"Behavior Pathology" is an able presentation of what medicine and psychology know about normal and abnormal behavior and the trends of thought and opinion that have in general been accepted by science. Since, however, both psychiatry and psychology are still young and immature it is perhaps wise to be wary of too definitive an attitude. The authors themselves do not claim to have written the last word nor the only explanation of behavior pathology. They have, however, fulfilled their purpose by making available a practical approach to the understanding of the biosocial maturation and adjustment of human beings in our modern complex civilization.

The book is well organized including an unusually full name and subject index, which enhances its value as a source of reference. Appropriate space is given to definition of the field of behavior pathology, problems to be considered, and methods of study employed.

Throughout the 600 pages the authors never stray from their objective: the understanding of the behavior of the individual who reacts according to an inherited biological constitution in a manner modified from birth by his environment and life experience.

The authors are eclectic as to schools of psychiatry, accepting from each those concepts that have been proved to be scientifically valid and useful. They have avoided confusion in semantics by defining carefully, almost to the point of being pedantic, the terms they use. Moreover, these are usually self-explanatory. "Self-inaccessible" is preferred to unconscious and "sociopathic" to psychopathic personality. "Pseudocommunity," "de-socialization," "anticipant attitudes," "reaction-sensitivity," "role-taking," and "biosocial maturity" are defined and through illustration made clear and meaningful.

The section, "Anxiety in Normal Behavior," followed by "Anxiety in Behavior Pathology," merits reading by every doctor. Anxiety is omnipresent. If in normal behavior early stages are discerned and effectively treated, anxiety neuroses are forestalled.

The psychoanalytic view of repression is contrasted with that of contemporary behavior pathology, which attributes compulsive disorders to incomplete repression and hysterical inactivation to overcomplete repression.

Unlike many books on pathology the present volume does not stop short of treatment. It deals comprehensively with a variety of current therapies, including such widely different approaches as nondirective and psychoanalytic, narcosis, shock therapy, and surgery, together with group therapy, psychodrama, and play therapy with children.

There is recognition of the large and growing body of clinical observation, experimental findings, and empirically derived theory that enables the modern physician to understand the development and persistence of pathological reactions and indications for effective therapy leading toward biosocial health and mature, appropriate behavior.

"The therapeutic task in the field of behavior pathology is not an easy one," according to Dr. Cameron. "Patients who have acquired behavior pathology can seldom be tutored, cajoled or persuaded into more effective ways. Nor does verbal communication alone guarantee enduring changes in behavior. Therapy is a great deal more than this. It involves a carefully planned personal inter-relationship between a patient and a highly trained therapist, and often between patient and other patients, and other trained workers."

Treatment in behavior pathology is not restricted to psyche or soma, but encompasses the total behavior of the patient as an individual living in a specific environment, in which he needs to learn or relearn social techniques that will enable him to function effectively as a human being. Therapy helps him to attain the status of a self-disciplined, mature adult who is capable of getting along with himself, and with his fellow-men—and of making a contribution to society.

WILLIAM B. TERHUNE, M. D.,
New Canaan, Conn.

MANIC-DEPRESSIVE PSYCHOSIS AND ALLIED CONDITIONS. By *Leopold Bellak, M.D., et al.* (New York: Grune and Stratton, 1952. Price: $9.75.)

This book is the second of two by the same author that are devoted to an identical task, namely, a summary of the recent literature. The first volume, entitled *Dementia Praecox*, was published in 1948. As with the first book the second is not a critical work; this was not the author's aim. Its main value

to the practicing psychiatrist, to the teacher or research worker, is that here are reviewed about 1,200 articles and books. These are conveniently arranged into the following chapters: Part I, Manic-Depressive Psychosis: Definition and Description, Vital Statistics, Etiology, Physiopathologic Studies, Psychopathologic Studies, Diagnosis and Symptomatology, Manic-Depressive Psychosis in Childhood, Treatment, Complications and Sequelae, Prognosis, Prevention; Part II, Allied Conditions: Psychotic Reactions to Pregnancy, Involutional Psychoses, Reactive Depressions, Depressions of Old Age, Suicide.

Bellak introduces his own conception of manic-depressive psychosis in an introductory chapter. This he calls a multiple factor psychosomatic theory. Psychosomatic means that the etiologic elements may be primarily psychogenic or somatogenic, but always involve an admixture of the two. The clinical condition of manic-depressive psychosis consists of several widely differing syndromes with different etiologic factors and these may be anatomic, biochemic, physiologic, genetic, neurologic, or psychologic. The author believes that all psychopathology can be placed on a continuum from the relatively normal at one hand and proceeeding through character disturbances and neuroses to manic-depressive psychosis and finally schizophrenia on the other hand. Psychopathology is determined by the libidinal structure of the personality and by the strength of the ego. An outstanding factor in the production of psychopathology is ego weakness, and this weakness is the result of faulty ego development or of afflictions of the cerebrum (histogenic, chemogenic, or genogenic of Cobb). The libidinal structure determines the content of psychopathology while the ego strength or organization determines the form which the content assumes. Psychopathologic symptoms are to be understood as compromise formations. These symptoms are an effort on the part of the individual to reestablish a state of equilibrium between a weakened ego and the libidinal forces. As the ego becomes progressively weaker, due to any cause whatsoever, one passes from character disturbance and neurosis through manic-depressive psychosis to catatonic episodes, paranoid states, and eventually to hebephrenic and total schizophrenic disintegration. The author proposes a schematic plan for the verification of this theory. The details of this plan and the theory itself cannot be done justice here, but must be read in the original.

In his theory Bellak is trying to construct a bridge between clinical diagnostic entities so as to bring these entities into one dynamic conceptual framework. He is concerned especially with the problem of the atypical or mixed cases, such as the "schizo-affective" psychoses and the reactive depressions. Such theories may be referred to as the continuum theories of psychopathology. All such holistic attempts are laudable and worth while, but if such continuum theories be true, why is it extremely rare to see a shift from a clear-cut schizophrenic state to a manic-depressive one? Or similarly, why does a person with a classical neurosis, say hysteria, so rarely develop schizophrenia?

P. E. Huston, M. D.,
State University of Iowa,
Iowa City, Iowa.

War-Handicapped Children. Homeless Children. By *Dr. Thérèse Brosse.* (New York: Columbia University Press, 1950. Unesco publications No's 439 and 573 respectively. Price: $0.50 each.)

These 2 publications are reports of conferences held under UN auspices on the problems faced in Europe concerning the social, educational, and psychological rehabilitation of hundreds of thousands of displaced and homeless children. These International Conferences of Directors of Children's Communities spelled out the scope of the problem, and matched what was being done for it with the thinking of experts in psychology, education, and psychiatry to work out a blueprint for the future. Some idea of the extent of the problem may be indicated by the reports that some of the children had not only moved many times in a few years, but had also twice changed their language, social environment, culture, religion, and even nationality.

Physical, psychological, and educational deprivation was found to be commonplace. The psychological manifestations included affect-less, bitter, insensitive, demanding, conscienceless, insecure, socially awkward, anxious, passive-withdrawn or hostile-aggressive children, often accompanied by a psuedo-mature type of worldly wisdom. From these children much is being learned about the influences of early life experience and the conditions under which the reversability of serious personality distortions is possible.

A remarkable aspect of these reports is the feeling one gets of the enthusiasm, hopefulness, and intensity of the personnel working with these children, in spite of a divergence of approaches and levels of training brought to bear on the problems involved. There seems to be an impatience with "traditional" methods and institutions not meeting the children's needs or moving fast enough toward the over-all objective of "preparing children of the world to undertake the responsibilities of free men," and "to contribute to a lasting peace."

Reginald S. Lourie, M. D.,
Washington, D. C.

Studies in Lobotomy. By *Milton Greenblatt, M. D., Robert Arnot, M. D., and Harry C. Solomon, M. D.* (New York: Grune & Stratton, 1950. Price: $10.00.)

This book concerns the work on prefrontal lobotomies that was started in 1943. It is written by many authors who did various phases of the work on this subject and who studied the patients adequately before as well as after the operation. There is an extensive review of the literature that covers various theories and views. The material used in

this work was at the Boston Psychopathic Hospital, and the neurosurgery was performed under the direction of Dr. James L. Poppen, who used an open operative technique with modifications as first devised by Lyerly in 1937.

The majority of cases used for the operation were long-standing schizophrenics on whom various psychiatric and hospital treatments had been carried out over a considerable period and in whom prognosis was poor. After a careful analysis of 205 cases out of a study of 500, they found 40% were benefited enough to leave the hospital or to become self-supporting. For the remaining 60%, life was more tolerable for friends and relatives associated with the patients, and living became more enjoyable for the patients themselves.

From the historical standpoint the book is very thorough, covering the different types of operative procedures with remarks on unilateral and bilateral lobotomy operations. There is adequate discussion of both the open and closed types of operation, including a description of the procedures of topectomy, thalamotomy, and cortical undercutting. The type of cases best suited for the operation is mentioned under the discussion dealing with indications and contraindications.

The immediate postoperative results are well discussed under the postoperative state, including the complications resulting from the operation. A thorough study of the patient was made from the psychological standpoint before and after the operation. In summary, they found that the IQ had not materially changed as the result of the procedure. As regards the training, education, and rehabilitation following lobotomy, they found that the patients were more trainable and less distracted by external influences after the operation. The nursing care and postoperative treatment are also adequately discussed.

A rather thorough analysis was made of the 205 cases who were followed for a period of 1 to 4 years after the operation. The study embraced the patient's condition and history previous to the illness, the period of the illness with a description of various treatments used, and then the analysis of the patient's condition since the operation. In the post-lobotomy period, special attention was given to the personality change with particular reference to drives, ambition, ability to live in a civilized world and society and to engage in a gainful occupation. It was found that vocational rehabilitation and training may be suitable for such types of cases after operation, but it had best be started 4 to 6 weeks after the procedure.

Studies were made with reference to the autonomic nervous system using in the examination the electroencephalogram and the electrocardiograph. It was found that lobotomy interfered with both the inhibitory and excitatory autonomic centers in the cortex. They also found that there was no appreciable change in the blood pressure of these patients after the operation. The urinary incontinence found in a certain percentage of these cases was believed to be due to a hypertonic spastic bladder brought about by the release of the autonomic system from higher centers. The electroencephalogram showed a large slow wave at the operative site in the cerebral cortex, which tended to extend forward and backward from this point. This was found in the seizure cases, while it was absent in the ones that had no attacks.

The book covers 477 pages of well-written material concerning prefrontal lobotomy with the open technique on patients with long-standing psychiatric illnesses. It is a conservative discussion of the subject, giving a fair appraisal of the results that may be beneficial or objectionable to the family and friends who may live with the patient after the operation.

J. G. Lyerly, M. D.,
Jacksonville, Fla.

L'Ipersessualita come Fattore Degenerogeno. By *Marino Benvenuti.* (Pisa: Edizioni "Omnia Medica," 1950.)

By degeneration the author intends the development of deviations from normality from which a special type of heredity develops that more and more assumes structural pathologic character.

In the clinical study of various members of 2 families the author deals particularly with what he terms the "hypersexual constitution" and the erotic temperament.

He feels that glandular dysfunctions in the direction of hyperactivity are at the base of hypersexuality. He emphasizes the importance of organic sexual deviations in determining intellectual deviations as well as deviations along psychopathological lines of psychoneurosis and schizophrenic traits.

In the book a special chapter is devoted to the relationship of sexuality with constitution and with endocrine activities, another to the psychophysiology and psychopathology of hypersexuality. These chapters are very interesting for their rich bibliographic references.

Personality and sexuality are discussed in another chapter and, in his conclusion concerning hypersexuality as a factor of degeneration, the author feels that in his patients what has failed to materialize is the fusion of the appetite of senses (eroticism) with the loving tenderness, a fusion that constitutes the final mature sexuality.

The book is of value to all psychiatrists interested particularly in the special problem of hypersexuality, which has been somewhat neglected in comparison with hyposexuality and other forms of sexual deviations.

Armando Ferraro, M. D.,
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New York City.

New Concepts of Hypnosis: As an adjunct to psychotherapy and medicine. By *Bernard C. Gindes, M. D.* Introduction by *Robert M. Lindner, Ph. D.* (New York: The Julian Press, Inc., 1951. Price: $4.00.)

This book purports to introduce new concepts for hypnosis. Unfortunately the author has presented something quite different. One third of the

book is frankly historical, another third is devoted to a restatement of hypnotic approaches prior to 1900, and the remainder describes the author's personal techniques, with special attention to devices for limited purposes. Early approaches are presented noncritically, and developments since 1930 are largely omitted. A psychoanalytic orientation is claimed but not substantiated. A check of references showed only a small percentage of the hypnotic literature since 1930, and only one reference since World War II, namely, Brenman and Gill's *Hypnotherapy*, which abstracts earlier references. No reference is made to the score or more other books, or numerous articles since World War II. Why?

The introduction by Lindner is eulogistic of psychoanalysis, and asserts that the author has made significant contributions to the study of hypnosis. Why the publisher accepted the book with this title or why Dr. Lindner so endorsed it is hard to understand. The general medical audience to whom it is apparently but not specifically directed would be better advised to consult such standard and actually more up-to-date works as *Medical Hypnosis* by Wolberg and *Hypnotism Today* by LeCron and Bordeaux.

MILTON H. ERICKSON, M. D.,
Phoenix, Ariz.

CLINICAL APPLICATIONS OF RECREATIONAL THERAPY. By *John Eisele Davis, Sc. D.* (Springfield, Ill.: Charles C. Thomas, 1952. Price: $3.75.)

This monograph is one of a series in American Lectures in Physical Medicine, which admirably serves to inform busy people of the values of the forms of therapy grouped as physical, such as light therapy, fever therapy, manual therapy, etc.

The author is a well-known exponent of the value of recreation in physical and mental rehabilitation. He is well versed in psychology, of which his doctorate is proof. For a number of years he was in charge of recreations at the VA Hospital at Perry Point, Maryland, and for about a half dozen years has directed the recreational activities in all the VA hospitals. With his wide experience he is well qualified as an authority on the subject.

Among the subjects briefly treated are: Practical Application of Recreational Therapy; Traditional Theories of Play; Universality of Play Forms; Psychodynamics of Recreation; Psychological Appeal of Free Play; A Vehicle for Interpersonal Relationships; Levels of Recreational Expression; The Sensory Level; Other Nonverbal Levels; The Symbolic Level; Group and Individual Therapy; The Analytic Viewpoint; The Body Image Concept; Rationale; Modification of Exercise; Play, A Cooperative and Competitive Experience; Play Technique in Relationship to Psychotherapy; Psychodrama; Patient-Therapist Relationships in Psychodrama, and 26 other sections.

While each of these is treated briefly, all are covered adequately and should be of great assistance to all connected with the rehabilitation of patients, be they physicians, psychiatrists, nurses, occupational and physical therapists, or their assistants.

The author states that, while his subject is still in a developmental stage, already much has been learned of value and certain principles are already established.

He has adopted the Freudian view toward mental disorders and explains disharmonies of id, ego, and superego in clear fashion. There is a specificity in his statements that renders them of especial value to the seeker for knowledge of the therapeutic values of recreations. Not every director of physical exercises is fitted to apply them therapeutically. A very definite personality is necessary. These distinctions are clearly set forth.

Of especial interest, perhaps, are his definite directions for the use of recreations for patients who have had, or will have, psychosurgery, for it is his opinion that before such operations a course of recreational treatment should be given as in this way a better knowledge of the patient may be gained and postoperative conditions may be more easily evaluated. Considerable emphasis is laid on using this therapy for children and the word "child" is often found when one is expecting to read *patient*.

There are a number of forms for recording that should serve to diminish paperwork and yet preserve a maximum of information regarding individual patients. These have proved of service in determining the value of certain recreations in different psychoses.

The author is to be congratulated on presenting the subject so clearly and yet so briefly.

W. R. D.

PARACELSUS, MAGIC INTO SCIENCE. By *Henry M. Pachter.* (New York: Henry Schuman, Inc., 1951. Price: $4.00.)

Osler said: "I desire no other epitaph than the statement that I taught medical students in the wards."

Paracelsus said: "The patients are your textbook, the sickbed is your study."

Here at least was one point on which the sixteenth and twentieth century physicians were as one.

Probably of none of the great personages of history have there been more contradictory or various opinions than of Dr. Theophrastus Bombastus ab Hohenheim, called Paracelsus. Born the year after the discovery of America by Columbus, he typifies that extraordinary age of transition from mediaeval to modern, the first half of the sixteenth century, and in his career and teaching there is the inevitable blending of mysticism and science.

"Paracelsus, before Sudhoff took him up," writes Garrison, "was regarded as a cross between a mystic and a mountebank." Karl Sudhoff, professor in Leipsig, greatest medical historian to date, pursued the study of Paracelsus during 35 years or more. He brought together, edited, and published in 14 volumes the collected medical, scientific and philosophical works of Paracelsus (1922-1933). Because of Sudhoff's work the world of today has a juster appreciation of the great sixteenth-century physi-

cian-magus. Speaking before the Historical Convention in Rome (1905) Sudhoff said: "On this solemn occasion, medical Germany in all its centuries of scientific achievement could present no greater man than Paracelsus, in universality of thought and practical achievements or in the originality and geniality of his world-encompassing genius."

From Sudhoff's numerous studies, from the various editions of Paracelsus' works, from previous biographies and interpretations of his writings Dr. Pachter derived the material by research both in Europe and America that he has brought together in the present book—a remarkable story of a remarkable personality, with a vivid picture of the cultural currents and cross-currents of the early renaissance times in which he lived.

Like the sixteenth century itself Paracelsus looked both backwards and forwards. He could not emancipate himself entirely from the crudities of belief which, because of their prevalence, were the normal beliefs of the time. He espoused astrology and alchemy, but with a difference. He brought alchemy a long way toward chemistry and chemotherapy (he was the first to use the word chemistry). He spoke of the airy spirit or essence or "quintessence" of matter as "chaos"—a word that van Helmont, a century later, probably had in mind when he coined the word "gas."

Theophrastus tirelessly promoted the experimental method; he substituted reasoning for dogma; he repudiated alike the traditional formulae of Galen, Avicenna (whose *Canon* he burnt), Celsus (Paracelsus = beyond Celsus), and likewise the fossilized rituals of scholasticism. He practiced magic, but magic for him was only learning and utilizing the laws of nature whereby his achievements became miracles to those unacquainted with these laws. Base metal he turned into "gold" by immersing it in a copper solution; and he knew what he was doing. Foretelling the future was for him merely what astronomers do today.

Theophrastus' most distinguished patient was Erasmus, whom he treated whilst both were in Basle. Erasmus addressed him as "the highly expert doctor of Medicine" and added, "I am amazed to see how well you know me to the marrow although you saw me only once."

Paracelsus was a world traveller. "The earth has not created me as one of the settled. My father did not engender me as a resident. I readily make a country my fatherland; but I leave it as readily." For years his wanderings were in search of knowledge. Having as little respect for contemporary schools as for ancient authorities he journeyed throughout Europe, to England, to Alexandria, "always seeking the foundation of medicine." But more and more as time went on his migrations became compulsory. Tact, considerations of expediency, capacity for compromise were lacking in Paracelsus' makeup. His abuse of authorities who disagreed with him and his bitter polemics made many enemies where he might have made friends. At length he was welcome nowhere. His disciples had fallen away; his friends had disappeared. Disillusioned, embittered, reduced to beggary, he turned to religion; but he was still of the Bombast family and ironically he styled himself Professor of Theology. He retained his contempt for ecclesiastical authoritarianism. Luther and the Pope he characterized as "two whores discussing chastity." He despised dogma and ritual. Of the rite of baptism he had said, "God blessed the water to quench the thirst and to breed fish, but not to serve as a sprinkling against the Devil." His experience taught him, according to Pachter, that religious faith and science are incompatible. At first he had sought to reconcile the two, only to conclude at last that theology and science must part company. But, as the author puckishly remarks, "there still are scientists who persist in the foolish effort to prove God scientifically."

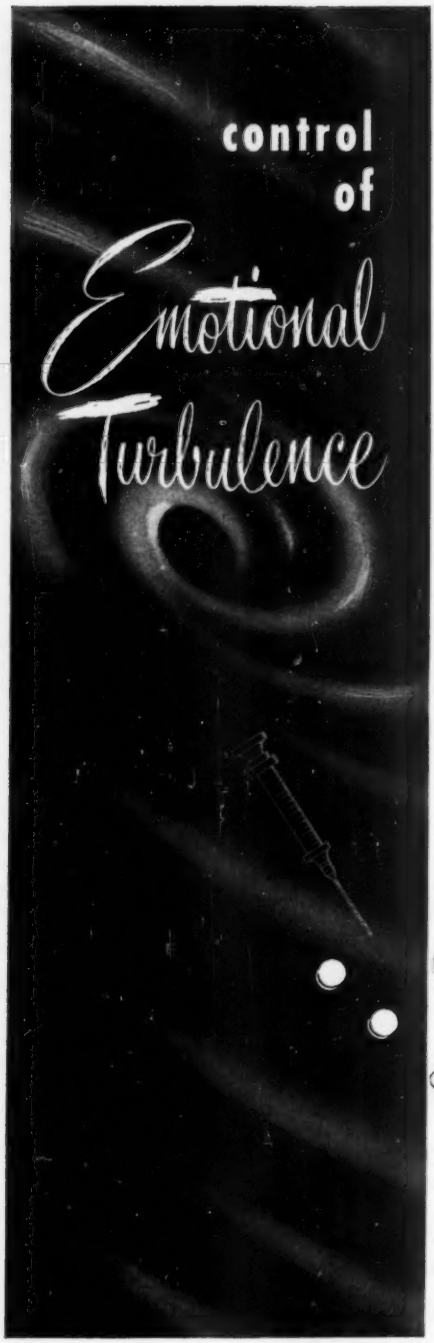
Emerging from his Slough of Despond in the mid-1530s, Paracelsus enjoyed a brief Indian Summer of popularity and prosperity and then died, already an old man, at forty-eight.

Of special interest is the fact that Paracelsus wrote a treatise on "The Diseases that Deprive Man of his Reason, such as St. Vitus' Dance, Falling Sickness, Melancholy, and Insanity, and their Correct Treatment" (v. Zilboorg's translation in Sigerist's "Four Treatises of Theophrastus von Hohenheim called Paracelsus," 1941). The preface by Paracelsus to his Treatise is noteworthy: "In nature there are not only diseases which afflict our body and our health, but many others which deprive us of sound reason, and these are the most serious . . . . we know from experience that they develop out of man's disposition. The present-day clergy of Europe attribute such diseases to ghostly beings and threefold spirits; we are not inclined to believe them. . . . Nature is the sole origin of diseases."

In a welter of extravagancies and obscurities relating to etiology, symptomatology, and treatment we find such startlingly modern statement as this: "Now we must speak about mania, which is a transformation of reason and not of the senses. . . . Mania has the following symptoms: frantic behavior, unreasonableness, constant restlessness, and mischievousness. It may be recognized by the fact that it subsides by itself and reason returns; mania may disappear and recur several times, or it may never recur."

Dr. Pachter's book contains a wealth of information that brings to life in unbiassed fashion this extraordinary renaissance figure, with commentaries on his numerous books—all against the background of the life and the psychological and theological climate of his time.

C. B. F.



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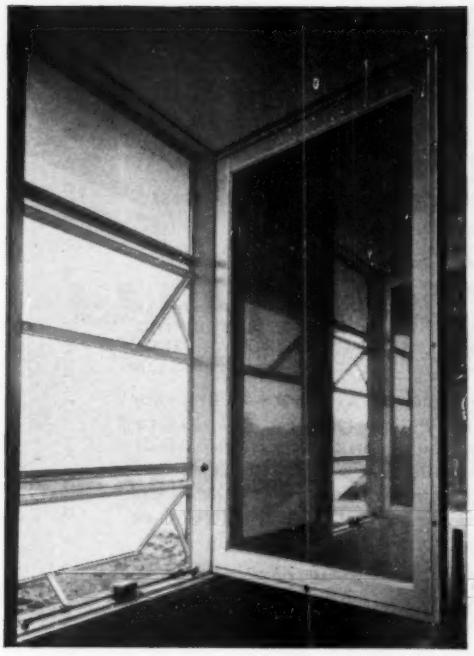

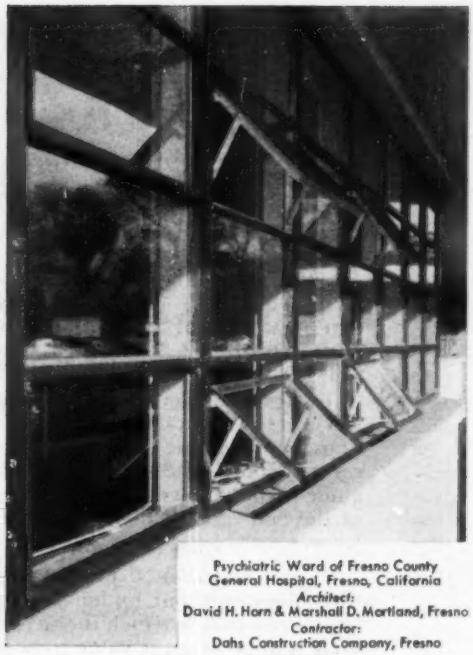

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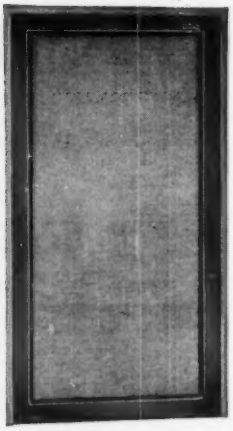

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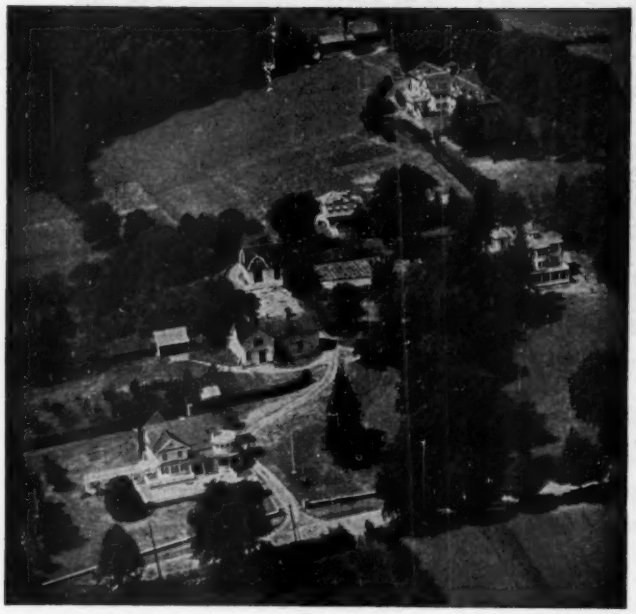

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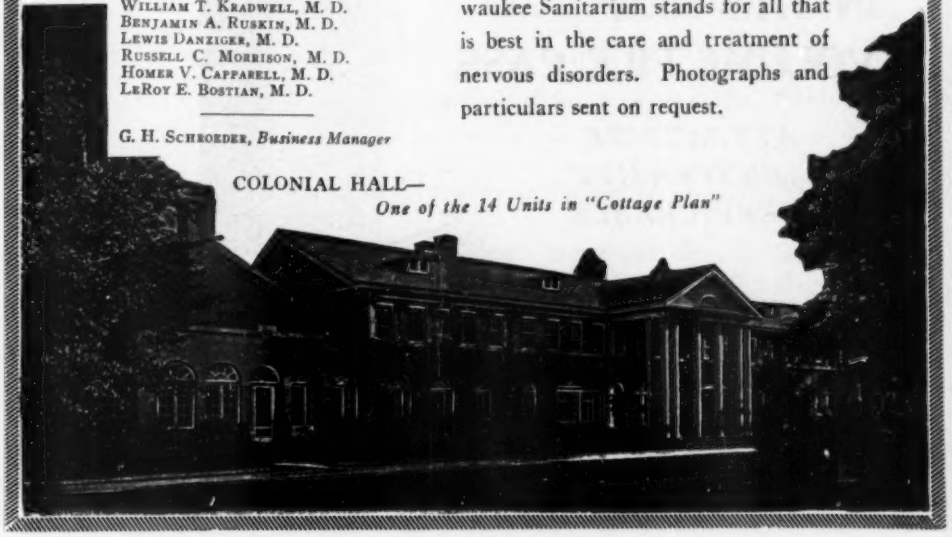

M/Sgt. Hubert L. Lee, USA Medal of Honor

FOUR TIMES Sergeant Lee's platoon had taken, then lost, the hill near Ip-o-ri. On the fifth try, the sergeant, though hurt, was leading. A Red grenade hit him, seriously wounding both legs. Refusing assistance, he advanced by crawling, rising to his knees to fire. He caught a rifle bullet in the back. Still he wouldn't be stopped. Finally, with 12 survivors of his platoon, he took the hill, then let the stretcher-bearers carry him away. Today Sergeant Hubert Lee says:

"In thirteen years of soldiering, I've seen brave enemies defeated—because things had collapsed back home. That's why I can appreciate what a good thing it is when people like you buy United States Defense Bonds.

"I'm told that you, and millions of others, own a total solid investment of *50 billion dollars* in our country's Bonds. That's good! That's *strength!* A man can face a hill when he knows that *people like you* are keeping our homeland strong."

* * *

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